S. Hrg. 98-1039

DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE

HEARING

BEFORE THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

EXAMINING THE EFFECTS ON PHYSICIAN PRACTICE PATTERNS RESULTING FROM THE PERCEIVED THREAT OF MALPRACTICE LITIGATION AND THE CONCERNS OF MEDICAL MALPRACTICE INSURANCE

JULY 10, 1984

Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE
38-509 O WASHINGTON : 1984

5541-72

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DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE

TUESDAY, JULY 11, 1984

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 9:20 a.m., in room SD-430, Dirksen Senate Office Building, Senator Dan Quayle presiding pro tempore.

Present: Senator Quayle.

OPENING STATEMENT OF SENATOR QUAYLE

Senator QUAYLE. The committee will please come to order.

This is the third hearing on health care cost related issues which the Committee on Labor and Human Resources has conducted this year. The first hearing examined health care technology assessment; the second explored alternative strategies for health care cost containment. Today the committee will focus its attention on two related issues, "defensive medicine" and medical malpractice. These issues may have significant implications for the cost of health care in this Nation.

I want to especially thank our committee chairman, Senator Hatch, for giving me the opportunity to chair these important hearings and to commend him for the compelling interest and concern I know he has in the areas covered in these hearings over the last few weeks.

For the purposes of our discussion here today, "defensive medicine" will be defined as the effects on physician practice patterns resulting from the perceived threat of future malpractice litigation. Also, for this discussion, the issue of medical malpractice will include the array of concerns surrounding the malpractice litigation process and medical malpractice insurance.

It is a commonly held perception that both defensive medicine and medical malpractice are major contributing factors in increasing health care costs. Estimates vary greatly as to the actual cost of defensive medicine. An American Medical Association report places the price tag for defensive medicine at $15.1 billion annually. Other groups have projected even higher figures. I look forward to this hearing shedding more light on the assumptions behind these various projections and possible mechanisms to reduce those costs.

Evidence also indicates that the cost to this Nation of medical malpractice is increasing dramatically. Prior to 1978 there were less than 3.5 claims annually per 100 physicians. Since that year, the average number of claims has grown to 8 per 100 physicians. It has further been suggested that the total cost of awards has increased, despite the State tort law reforms of the middle-1970's.

In response to these developments it is not surprising that medical malpractice premiums have been on the rise for both hospitals and physicians. Whereas these premiums seemed to plateau in the late 1970's in the years immediately following the first "medical malpractice crisis" with its requisite reforms, the 1980's have experienced a consistent upward trend in the cost of medical malpractice insurance. In several States I understand that insurers are now asking for premium rate increases in excess of 100 percent annually. Nationwide, rates have increased 20 percent per year in the 1980's, and the increases have been even greater for specific specialties, such as obstetrics.

A few States, like my home State of Indiana, have avoided these premium increases, but this has been the exception. Most States have not been able to emulate the success of Indiana, and I will be interested today to hear the insights of our witnesses on the reasons for this.

The objectives of this hearing today will be to determine the extent to which the defensive medicine and the medical malpractice systems influence health care costs; identify those problems which lie at the base of the defensive medicine and medical malpractice issues; discuss remedies to these problems, and ascertain the most appropriate Federal role, if there is one, in helping solve these problems.

The public sector response to the mid-1970's medical malpractice crisis was centered at the State level. This occurred primarily because insurance and tort law, historically, have come under the jurisdiction of the States. By 1976, 48 of the 53 jurisdictions of this country—50 States, the District of Columbia, Puerto Rico, and the Virgin Islands—had established by statute a plan to assure the availability of malpractice coverage for providers in their areas. Although these reforms succeeded in solving the insurance availability problem, over the long run they do not seem to have abated the growth in cost to the health care system of medical malpractice, or reduced the incentives for physicians to practice defensive medicine. Since the Federal Government assumes a large portion of this Nation's health care bill and has provided leadership in the area of health care cost containment, we are reviewing these issues today.

It appears that concerns over another medical malpractice crisis are reaching a new crescendo. This crisis presents Congress with a set of social and moral concerns, as well as financial and budgetary issues. Public policy must be developed which is sensitive to the needs and concerns of the patient and his family, as well as the provider and payer. Balancing these interests will not be simple, but any reform must assure that all sides are treated fairly and equitably.

I wish to thank all of our witnesses who have taken time from their busy schedules to appear before the committee and look forward to all the testimony.

Senator Hatch has a statement that will be inserted in the record at this time.

[The prepared statement of Senator Hatch follows:]

STATEMENT OF SENATOR ORRIN G. HATCH
DEFENSIVE MEDICINE HEARING
JULY 10, 1984

I am pleased that my colleague, Senator Quayle has offered to chair full Labor and Human Resources Committee today related to defensive medicine and medical malpractice. When I was a practicing attorney, I had the opportunity to serve as council on several medical malpractice cases. As chairman of this committee, I have learned a great deal more about health issues, particularly the problems related to run-away costs. I welcome the information the expert witnesses will provide today in their respective testimonies and hope we might better understand how the federal government might work with state governments and professional organizations to reduce the health care expenditures, without compromising quality. The issue of defensive medicine is one which affects us all, either directly or indirectly, as taxpayers, insurance holders, patients and relatives of patients. This issue has greatly influenced both cost and quality of medical care in recent years, and will continue to do so unless something is done.

In speaking of defensive medicine we refer to physicians' behavior in response to a perceived threat of future malpratice litigation, including such activities as performing extra procedures, ordering additional diagnostic tests, or even refusing to treat certain high risk patients. We have scheduled this hearing because of our concern that this aspect of the current health care system is contributing to ever increasing health care costs.

It is difficult to determine the extent to which defensive medicine contributes to heatlh care costs because of the lack of reliable data. However, the American Medical Association (AMA) Committee on Professional Liability recently estimated that the total cost of defensive medicine was $15.1 billion in 1983 alone, a very large chunk of total medical treatment costs. Also, the AMA surveyed a sample fo 1240 of its members in 1983 to determine how physicians have changed their usual patterns of practice in response to rises in professional liability premiums. Of the 1240 doctors surveyed, 40.8 percent reported prescribing additional diagnostice tests, 27.2 percent provided additional treatment procedures, 35.9 percent spent more time with patients, 56.7 percent kept more detailed patient records, 44 percent refer more cases to other doctors, 34.6 percent no longer accept certain types of cases, and finally, 31.4 percent reported increasing their fees for services to recover their increased cost of professional liability insurance. These reponses suggest that many doctors are adopting a defensive approach to medicine.

In examining the data, analysts have accused three chieff culprits for encouraging defensive medicine: 1) an increase in premiums for physicians liability insurance; 2) an increase in malpractice claims; and 3) the relationship between performance of medical procedures and the reimbursement policies of the current health insurance system of the United States.

It is my hope that this hearing will address not only economic issues, but also the psychological aspects implied in the defensive medicine concept. Also, I hope to learn whether there is an appropriate role for the federal government in this important issue. I have listened to cries for help from many physicians in my home state of Utah, as well as throughout our country. But before Congress enacts a legislative solution, which would herald the federal governments involvement in yet another aspect of our citizens' lives, I recommend we proceed with careful deliberation. I commend Senator Quayle for contributing his time and energies to the all important issue of health care cost containment and look forward to the information these hearings will provide.

Senator QUAYLE. Our first panel is Patricia Danzon, Clark Havighurst, Arnold Rosoff, and Barry Furrow. We will start with Ms. Danzon. For the convenience of the Chair and also the witnesses and the audience, we will be operating under the 5-minute rule. I will have a little light system right there. Your entire statement will be inserted in the record, and I ask for you to summarize your testimony in 5 minutes. The green light means keep going; the amber light means you have about 30 seconds left, and the red light means "cut." You can go over that a little bit if you want to, but that does mean you have gone beyond your limit.

So, Ms. Danzon, would you proceed, please?

STATEMENT OF PATRICIA M. DANZON, PH.D., ASSOCIATE PROFESSOR, CENTER FOR HEALTH POLICY RESEARCH AND EDUCATION, DUKE UNIVERSITY

Ms. DANZON. Thank you. Mr. Chairman, my name is Patricia Danzon; I am an associate professor of economics at Duke University. I have been studying the medical malpractice problem for the last few years and have been particularly concerned with evaluation of the efficiency of the malpractice system in its dual roles of determining medical negligence and compensating its victims.

The conclusion that I draw from this research is that although the malpractice system is costly, its costs tend to be exaggerated. The costs of the malpractice system are far less than the costs of malpractice—the injuries that occur due to medical negligence.

The malpractice system is worth retaining as a system of deterrence of medical negligence, but it can be made more costeffective by some reforms which I shall discuss.

I believe that the no-fault proposal presently being debated in Congress could be a disaster, could be extremely costly, and many of its benefits could be achieved without abandoning the full principle. Let me go over these points very briefly.

First, the cost of malpractice insurance is currently around 1 percent of the total cost of health care. Thus, the notion that malpractice insurance is driving the rising cost of health care is exaggerated. This 1 percent is comparable to the percentage that malpractice premiums represented in 1970.

Second, "defensive medicine." There are no reliable estimates for "defensive medicine," but again, I think there is a tendency to exaggerate. There are certainly a lot of unnecessary testing and unnecessary procedures being done, but much of this results from the incentives being created by the fee-for-service reimbursement system. It would not go away if we abolished liability for malpractice. Moreover, many of the responses that physicians report, such as spending more time with patients or referring difficult cases, these are precisely the sorts of care that the malpractice system is intended to encourage. They should not be considered wasteful.

It is also said that the malpractice disposition of claims is an "erratic lottery." From a study of over 6,000 claims, I conclude that both the courts and the settlement process lower the precepts of negligence law to a fair degree. Most claims receive awards roughly comparable to their economic loss.

We get a very biased impression of the total tort system from the few, very atypical cases which go all the way to verdict. Some of the tort reforms enacted after the last crisis have had an effect.

Although the costs of the malpractice system are high, they are small compared to the costs of malpractice. Based on estimates of the number of injuries occurring in California hospitals, I estimate that the costs of injuries due to medical negligence are at least 10 times the costs of malpractice insurance premiums, currently, roughly $24 billion. Therefore it is worth spending something to try to reduce this incidence of negligent injury, and I believe that the malpractice system serves this purpose.

Unfortunately, we cannot measure the number of injuries that do not happen because physicians are more careful as a result of the threat of liability. However, I estimate that if the incidence of injury would be only 4 percent higher were it not for the malpractice system, the malpractice system pays for itself. In other words, if it eliminates only 4 percent of the injuries due to medical negligence.

But I am not simply defending the status quo. I believe the malpractice system could be made more costeffective by the following reforms.

First, awards should be restructured to eliminate compensation for pain and suffering. Payment should be made according to a schedule. Payments should be made periodically.

With respect to the statute of limitations, I advocate a short statute, say, 3 years for adults, running from the time of injury, not from the time of discovery.

The standard of care should be revised to take into account the costs. If physicians can show that performing or omitting a procedure is justified after weighing the costs, risks, and the benefits, this should be a justifiable defense against a claim alleging malpractice.

Contracting out of the tort system should be encouraged, and Professor Havighurst will go into this in more depth.

Finally, I believe the no-fault proposal currently before Congress could lead to an increase in claims of over fiftyfold. It could become a system of national catastrophic insurance. If we want to have a system of national catastrophic insurance, we should expand the existing programs we have—Social Security, medicare—and not foist it on the medical liability system.

Thank you.

[The prepared statement of Ms. Danzon follows:]

TESTIMONY BY PATRICIA M. DANZON, PRESENTED TO THE COMMITTEE ON LABOR AND HUMAN RESOURCES, U.S. SENATE
JULY 10, 1984

I am a Ph.D. economist, specializing in the application of economics to evaluate public policy, particularly health policy. I have worked on health policy at the Rand Corporation, at the Hoover Institution at Stanford University, and now at the Center for Health Policy at Duke University, where I also teach economics and health policy.

For the last few years, the major focus of my research has been medical malpractice. The medical malpractice system we have today is designed to perform two functions: deterrence of medical negligence and compensation of its victims. As an economist, my concern is with the efficiency or cost-effectiveness of this system, from a social standpoint. In order to understand how the malpractice system actually operates in practice, to distinguish fact from allegation, and to evaluate proposals for reform, I have undertaken several detailed empirical studies of the disposition of malpractice claims, the determinants of claim frequency and severity, the effects of the tort reforms enacted in response to the last crisis, the causes of that crisis and the operation of malpractice insurance markets. My findings are the subject of a forthcoming book on public policy towards medical malpractice.

Today I would like to make five points:

1. The malpractice system is costly and imperfect but these defects are often exaggerated.

2. The cost of malpractice -- the real social cost of the injuries due to medical negligence -- is many times greater than the more visible costs of malpractice insurance premiums and wasteful defensive practices. Therefore in considering reform, we should be at least as concerned about the deterrence of malpractice as about the cost of malpractice claims.

3. The current negligence or fault-based approach is worth retaining as a system of quality control -- a deterrent to malpractice.

4. The malpractice system can be made more efficient by several specific reforms, which I shall discuss.

5. A no-fault approach such as that embodied in S.2690 could be a disaster. Restructuring the medical liability system solely to provide more extensive compensation is not worthwhile. Compensation can be achieved more efficiently and more equitably through existing insurance programs.

Let me now elaborate on each of these points.

1. DEFECTS OF THE MALPRACTICE SYSTEM ARE EXAGGERATED.

Malpractice Insurance. The allegation that malpractice insurance is a major factor driving the high and rising cost of health care is exaggerated. Between 1975 and 1982 malpractice insurance premiums rose roughly 73%, while the cost of physicians' services rose 92% and the cost of a hospital room rose 130%. Overall, malpractice insurance premiums account for around 1% of the $350 billion health care bill. For physicians, malpractice insurance premiums average around 3% of their gross income, ranging from 1-2% for general practitioners to 5-6% for high-risk surgical specialties. These percentages have increased only slightly since 1970.

The recent round of increases in malpractice insurance rates follows several years of little or no increase. There is currently no lack of availability of insurance except in states where rates are heavily regulated to levels insurance carriers deem inadequate for the risks involved. Similarly, the availability crisis of the mid-seventies was largely the result of regulation. Price controls in any market discourage supply and lead to shortages. The only difference in insurance markets is that the resulting shortage is called an availability crisis.

Defensive Medicine. Defensive medicine is rarely precisely defined and has never been reliably estimated. I shall define as defensive medicine any waste of resources (net excess of costs over benefits) that results from physicians changing their practice patterns in response to the threat of liability. There is no doubt that many tests and treatments are performed which are not cost-effective -- the costs exceed the expected benefits. But most of this is not defensive medicine. It is the result of the incentives for overutilization built into our traditional fee-for-service system of health insurance. Prospective payment or capitation-based reimbursement for health care, which reverse the financial incentives facing providers, would do far more to eliminate excessive utilization than would abolition of liability for malpractice.

On the other hand, some physician behavior that is correctly ascribed to the liability threat is not pure waste. Spending more time with patients, referring difficult cases -- these are precisely the types of increased care which the malpractice system is intended to encourage.

An erratic lottery? The allegation that the tort system is an erratic lottery is exaggerated. My analysis of the disposition of malpractice claims shows that the courts and the settlement process follow the legal precepts of negligence law to a fair degree. Over 90% of claims are settled out of court. Two-thirds are closed within two years of filing. On average, claims settle for 74% of their potential verdict (the expected award, had the plaintiff pursued the case to verdict and won). Some of the tort reforms enacted in response to the last crisis have indeed made a difference. In particular, caps on awards and mandatory reduction of awards by the amount of collateral benefits have significantly reduced verdicts and settlements in states that enacted such changes. In general, one obtains a very biased perception of the malpractice system as a whole from the few highly publicized but atypical cases that win huge jury verdicts. These cases are litigated precisely because they involve unusually difficult issues and severe loss.

2. THE REAL COST OF MALPRACTICE.

The visible costs of the malpractice system -- insurance premiums, defensive practices -- are small compared to the less visible but far larger costs of malpractice -- the injuries that occur due to medical negligence. A 1974 study by the California Hospital Association and California Medical Association showed that roughly one in 126 hospital admissions results in an injury due to medical negligence.[1] I estimate that at most one in 10 of these injured patients filed a claim, and at most one in 25 received compensation through the tort system. A rough estimate of the cost of these injuries is $24 billion, or 10 times the cost of malpractice insurance premiums. It is surely worth incurring some expense to reduce this incidence of injury due to negligence.

3. MALPRACTICE AS A SYSTEM OF QUALITY CONTROL.

Unfortunately we cannot measure the deterrence benefits of the malpractice system -- the injuries that are avoided because the threat of liability makes physicians and hospitals more careful. But one can make some rough calculations of the amount of deterrence necessary to justify the additional costs of litigating over fault. Ignoring defensive medicine, I estimate that if the incidence of negligent injury would be at least 4% higher, were it not for the threat of liability, the malpractice system pays for itself. The extra costs of litigation are offset by the savings in injuries prevented. Even if we triple the estimate of cost to allow for defensive medicine, only a 12% reduction in the incidence of negligent injury is required to justify the tort system. If such estimates do not strike you as implausible, the fault-based approach is worth retaining.

It is often argued that the malpractice system does not and cannot deter because what is called malpractice is typically error of judgement that would not be avoided by being more careful. This claim is belied by the evidence. The California study concluded that problems of performance, rather than purely judgemental issues, were overwhelmingly responsible for the medical injuries that occur in hospitals. Similarly, improper performance is the most common allegation in malpractice claims.

Admittedly there are other mechanisms of quality control -- licensure and accreditation, peer review, etc. They serve a useful function. But they cannot monitor every patient-physician encounter. The advantage of the tort system is that it provides a continual, ongoing system of "regulation by incentives." And it does not rely on enforcement by the medical profession which, like any other profession, is notoriously reluctant to police its own members. To illustrate, in California in 1976, there were 1,500 paid malpractice claims, but only six disciplinary actions for incompetence or gross negligence.

4. REFORMS

The tort system could be improved by the following reforms:

Awards (i) Scheduled awards for economic loss only. Awards for damages should be restructured to resemble more closely the insurance people buy voluntarily. After all, in its compensation function, the tort system is simply a form of compulsory insurance, which we are all required to buy when we buy health care. When faced with the choice -- and the bill -- most of us do not buy insurance against pain and suffering. The tort system should provide compensation for loss of earning capacity (after tax) and for reasonable medical expenses, rehabilitation and other monetary costs. Pain, suffering and other nonmonetary losses are very real losses, but money cannot replace them. That is precisely why most of us do not choose to insure against them, and the tort system should not force us to.

Payments should be based on a schedule, as in workers' compensation, not determined on an individual, case by case basis. Individualizing awards encourages expenditure on litigation, is inefficient insurance and adds nothing to deterrence. Payment according to a schedule, based on age and injury severity, is superior to the single ceiling or cap which some states have enacted. Such a uniform limit tends to hit hardest the young, severely injured plaintiff, who has the largest economic loss.

Note that although reforms of this type are usually advocated as part of a no-fault system, that is not a necessary connection. These changes make sense on grounds of economic efficiency, while retaining the fault-based liability rule. A federal model bill proposing such changes for all branches of tort law, not just medical malpractice, could contribute to overriding the constitutional objections to limiting awards solely for the victims of medical malpractice.

(ii) No reduction in the tort award on account of other, collateral sources of insurance coverage. But all private health and disability insurers should have rights to seek reimbursement (subrogation) for expenses they incur. Payments under public programs -- Social Security Disability Insurance, Medicare and Medicaid -- should be reduced by the amount of the tort award. This would eliminate double compensation while transferring the cost of the injuries to the parties responsible. Such "internalization" of costs is essential for deterrence.

(iii) Periodic payment for permanent injuries, through an annuity or trust fund set up by the defendant at time of settlement. This should revert to the defendant (or his insurer) in the event of early death of the plaintiff, minus reasonable payment to his estate. Note that although the payment should be periodic, the amount should be determined at time of settlement. Periodic payments that are contingent on expenses actually incurred create inefficient incentives to delay rehabilitation and to incur unnecessary expense.

(iv) An uninsurable fine on the physician or hospital, in cases of severe injury due to gross negligence. This uninsurable fine would replace punitive damage awards. The fine should be paid to the state and used to defray the public costs of the courts.

Statute of limitations. I advocate a short statute of limitations -- say, three years for adults, ten years for minors -- running from the time of the injury, not from its discovery. (Such a statute is also often called a statute of repose.) The reason is that with rapidly changing technologies, volatile legal rules and social standards, a long statute of limitations exposes physicians to a severe risk of retroactive application of standards that were not relevant at the time care was delivered to the patient. Such retroactive application of new standards serves no useful deterrent function, is inequitable, is inefficient insurance and has contributed very significantly to the cost of malpractice insurance and to disruptions in malpractice insurance markets.

Standard of Care. The standard to which the physician is held is the "customary practice of physicians in good standing." Unfortunately, customary practice is not necessarily efficient practice because of incentives created by excessive health insurance and fee-for-service reimbursement. There is movement underway towards more cost-effective modes of health care delivery, as the private sector and the public programs experiment with HMOs, prospective payment, preferred provider networks, etc. If these efforts are to succeed in eliminating inefficient practice patterns, they must not be held to the customary norms of traditional fee-for-service medicine. If a physician can show that performing -- or omitting -- a procedure is justified after weighing the costs, the risks and the benefits, this should be recognized as a defense against a malpractice claim.

Contracting out. The tort system mandates a rule of liability, a standard of compensation and a system of dispute resolution that may well exceed what patients would be willing to pay for, if given the choice. If physicians, hospitals, insurers and patients enter into contracts that provide for alternative standards of compensation or methods of dispute resolution, such contracts should be honored by the courts, as explicit evidence of the preferences of the parties involved. Some private contracting already exists -- for example, some HMO contracts provide for binding arbitration. However, federal legislation explicitly authorizing and establishing guidelines for valid contracts would encourage contracting out, by resolving the ambiguity as to their legal status.

5. NO-FAULT COULD BE A DISASTER.

A comprehensive no-fault approach to compensation for medical injury would degenerate into an extremely costly and inefficient system of national health and disability insurance. It would be a disaster.

The quasi no-fault bill currently before Congress (the Alternative Medical Liability Act, S.2690) has some of the same problems, if to a lesser degree. Under this bill, a defendant could foreclose a civil action by offering to settle, on a no-fault basis, for the amount of the plaintiff's monetary loss and reasonable legal fees, less compensation payable from collateral sources.

If malpractice defendants or their insurers routinely made settlement offers on a no-fault basis, as the bill intends, any patient who suffers an adverse health outcome could file a claim, whether or not negligence had occurred. The number of claims filed could increase at least fifty-fold. This estimate of the potential increase, based on the California data on medical injuries, makes no allowance for invalid claims, i.e., claims involving incomplete cure despite the best possible medical care. In fact, I suspect that defendants would frequently not offer to settle but would incur the expense of litigation in order to stop the potential avalanche of claims that would occur if settlement were automatic. Thus whether the bill would in fact deliver the promised benefits of fairer and more prompt settlement for more people, is far from certain.

Several of the goals of S.2690 could be better achieved by the tort reforms outlined above. As I argued earlier, eliminating payment for nonmonetary loss need not be tied to a no-fault liability rule, nor should it be confined to cases that settle out of court, as S.2690 proposes. Scheduled awards for monetary loss only would not only eliminate wasteful compensation, but would also reduce incentives for litigation and delay, and reduce insurance risk. Prompt settlement could be further encouraged by requiring that the defendant pay pre-judgement interest at prevailing market rates, from the date of filing to settlement.

While the benefits of a quasi no-fault bill are uncertain at best, S.2690 would add costs in at least three important ways.

First, the proposal to pay future expenses as they accrue is an open invitation for plaintiff delay in rehabilitation and for litigation over what constitutes reasonable expense.

Second, waste due to defensive medicine may well increase. Even if the stigma of fault is removed, the physician or hospital still incurs an expense in settling a claim and therefore has an incentive to avoid high-risk patients or procedures. Physicians' incentives to avoid high-risk situations would be greatest in the case of uninsured and underinsured patients -- those with chronic problems, newborns, the poor and the elderly who have exhausted their Medicare coverage -- because the defendant pays only for monetary loss not covered by other insurance.

Finally, if the quasi no-fault system operated as intended, it would effectively act as a form of national catastrophic health and disability insurance. This is not the place to discuss the merits of a national catastrophic insurance program. Suffice it to say that if we opt for such a system, it should be operated and funded as a separate program, not as an add-on to the medical liability system. In fact, Social Security Disability Insurance, Medicare and Medicaid already provide a very substantial safety net for those without adequate private insurance. If our concern is compensation, we would do better to close the holes in this net of programs which serve everyone, rather than devise an expensive add-on program confined to the victims of medical injury.

In conclusion, I believe that the fault-based malpractice system, reformed along the lines I have suggested, is worth retaining as a deterrent to medical negligence. For purposes of additional compensation, we already have extensive private and public health and disability insurance programs. If this security net has gaps, they should be closed, but not partially patched through the medical liability system.

1. Report on the Medical Insurance Feasibility Study, California Medical Association and California Hospital Association, Sutter Publications, Inc. (1977).

Senator **Quayle**. Thank you very much.

Also from Duke University, professor of law, Clark C. Havighurst.

STATEMENT OF CLARK C. HAVIGHURST, PROFESSOR OF LAW, DUKE LAW SCHOOL

Mr. **Havighurst**. Thank you, Senator Quayle.

I am in the law school at Duke, and Professor Danzon and I have not—she's only been at Duke a short time, and we haven't had occasion to work together much, but it's a pleasure to have her at Duke. She is surely preeminent——

Senator **Quayle**. Well, we're glad to provide a forum for you two. [Laughter.]

Mr. **Havighurst**. Thank you.

I've worked on health care problems, the legal problems of the health care industry, for quite a long time now. My major academic interests are in the fields of antitrust and economic regulation, and it's been from that point of view that I've pursued the health care industry's problems. I have not worked in tort law, and it may help you to understand my comments today to understand that I'm not a torts teacher.

What I want to do here is to focus on the problem of medical malpractice from the standpoint of national health policy. I think that by viewing the problem this way, and not in isolation as it's usually viewed, it may be possible to identify some new ways in which this problem can be attacked. Specifically, I want to argue that the new competitiveness of the health care industry makes it possible to contemplate, nearly for the first time, the reform of liability rules by private rather than by governmental action. It seems to me that the time has come to recognize that health care providers, particularly competitive health care plans such as HMO's and preferred provider organizations, might agree with their patients that they would be bound by a different set of rules than those that the courts and the legislatures have laid down.

Essentially, then, I want to suggest that the private sector, instead of waiting around for Government to solve this problem, should recognize that the law, as the courts and the legislatures lay it down, isn't necessarily the final word, and that within some limits, at least, private parties can write their own rules in private contracts.

Now, there are going to be questions about the enforcability of some of these contracts, and they are appropriate questions; but the courts, I think, should approach such contracts with an open mind. A pure exculpatory clause which would purport to protect the writers from suits of any kind might be the most objectionable kind, and some courts have found such agreements to be invalid under public policy considerations. But those holdings seem to me not to prevent less sweeping alterations in the rights of patients in the event of a medical injury, and it seems to me that the kinds of agreements that I'm going to try to sketch for you might be considered on their own merits and not objected to solely on the basis that patients may not have totally understood all of the implications of the agreements they're entering into.

Let me spend a minute, though, to concentrate on what brought about this new opportunity that I see for using private contracts to change liability rules. This is a new opportunity, it seems to me; it hasn't been around very long. When we didn't have effective competition in health care, everybody assumed—and perhaps correctly—that consumers had few opportunities to choose, and nobody thought that they had much capacity to make choices. I think we're rethinking that now. Essentially, consumers in the old days took what the medical profession prescribed, and it was natural under those circumstances to assume that consumers couldn't exercise choice about liability rules, either. They were required to take what the legal system prescribed. And it seems to me that the coming of competition is the result of Federal policies encouraging prepaid health plans, enforcement of the antitrust laws, and other things—these have tended to change all of this. Consumers now are purchasing through employment groups; they have more choices available; they have help in making choices, and it seems to me we have new opportunities to solve problems of all kinds through that mechanism.

Competition, then, gives consumers for the first time a chance to escape the burdens of professional monopoly—not only the burdens of the medical profession's monopoly, but the burdens of the legal system's monopoly over the making of legal rules about what happens when there's an injury.

Now, the criticisms that one hears of the tort system are, I think, valid. Professor Danzon has gone into some of those. She is not as critical as most people, but she does recognize the need for substantial reforms. I do as well. I think it's hard to say whether this system is worth its high cost, and I think she admits that and frames the question in an appropriate way.

In any event, I think that the criticisms of the tort system are strong enough that we ought to recognize that patients and providers ought to have a chance, at least, to change the rules themselves by negotiating a different set of rules.

I recognize that politics and the uncertainty about exactly what ought to be done about this problem make legal change difficult, and it seems to me that that should suggest leaving more room for private reform. There's an awful lot of opportunity here for saving money, and that money could be used to—you save the money by cutting out the lawyers, in effect, and by reducing the very large awards to some patients and spreading the money around more. But it's possible to compensate more people with the same amount of money, or to reduce fees or insurance or HMO premiums, or to improve the quality of care and provide more services. It seems to me that there's a lot to be gained.

Just let me mention a few of the kinds of contracts that might be brought to bear. I already mentioned exculpatory clauses, which are the hardest to defend. Arbitration contracts have been accepted by the courts; even where a patient didn't know that an employer had waived his right to a jury trial, and even in California where it's hard to get any contract enforced, according to its terms.

Another possibility is a contract that would limit the dollar amount of awards. Some States have set limits on dollar amounts that could be awarded; why can't private parties voluntarily agree to set some limits? They could set a flat limit, as some States have done, or they could, say, limit recoveries to the economic loss. They might adopt a limit on recover of the same kind you find in S. 2690, a limit to net economic loss if an offer of settlement is made within 6 months.

Another possiblity is that providers and patients might agree that providers would be held to a different standard of care than that which is required by the malpractice courts. The courts have drawn their standard of care from customary practice—what doctors generally do. But that may be too demanding a standard. It's probably an inefficient standard. It originates in a market where insurance reduces cost-consciousness, where doctors pursue absolute patient safety, and where they take defensive measures that aren't necessarily beneficial to patients. An HMO that wanted to economize in a responsible way might find itself exposed to serious legal risks if it did so under the customary practice rule. It would seem to me that they might wish to agree with their subscribers that they could depart from customary practice under certain circumstances and in good faith, and so on.

You might also have an agreement simply that the patient couldn't sue except for gross negligence, or something else. How you draft these is complicated; that might be one of the more questionable kinds of agreements. But the point is, really, that there is a lot of room for experimentation here.

Finally, I could imagine substituting a no-fault compensation scheme which provides automatic compensation without regard to fault for particular designated injuries. Some years ago I proposed such a scheme and designed it in a way that would not eliminate, as most no-fault schemes do, the incentive to avoid adverse outcomes. To preserve that incentive seems to be very important, as Professor Danzon has indicated.

The American Bar Association studied the proposal that I made in the early 1970's, found that it was feasible and recommended more study, and we haven't had much more study. But it does seem to me that there is at least a potential for pursuing that idea and implementing it not through legislation, but through private contracts.

Mr. Chairman, my main point here really is that there are lots of ways that one could go in trying to deal with this problem. It isn't clear which is the best way to go; it seems to me an ideal case for letting the private sector have a chance to solve these problems voluntarily. I think that's the best place to turn.

My inclination, then, is to counsel the committee that we may not need Federal legislation at this time, that we should perhaps be looking to the private sector to provide some new ideas, to experiment with different approaches. It seems that in time, we might be able to solve the problem that way.

I am trying to organize now a conference for next year where we will try to get the private sector people together to start talking about using private arrangements to work these difficult problems out. I sure hope we can get that ball rolling. If we can, it seems to me we might actually solve this problem without having to bother the Congress too much.

Thank you.

[The prepared statement of Mr. Havighurst follows:]

Testimony of Clark C. Havighurst
Professor of Law, Duke University
Before the
Senate Committee on Labor and Human Resources
July 10, 1984

Mr. Chairman, my name is Clark C. Havighurst. I am a professor of law at Duke University with academic interests in antitrust law and economic regulation of business. Since the late 1960s, I have directed the Program on Legal Issues in Health Care at Duke and have studied and written about health care issues. Many of my writings have advanced the view that we have relied too heavily on government and not enough on the competitive marketplace to guide health care developments. I have also written about alternatives to traditional tort law mechanisms for compensating victims of medical accidents and ensuring the quality of care.

In these remarks, I want to consider the problem of medical malpractice from the general perspective of national health policy. By viewing the problem in this fashion and not in isolation, I hope to call attention to a new way in which it might be attacked. Specifically, I wish to argue that the new competitiveness of the health care industry -- fostered through such federal policies as encouragement of prepaid health plans and aggressive antitrust enforcement -- has opened exciting possibilities for private, as opposed to judicial and legislative, reform of the rules that govern liability for injuries suffered by patients in the course of medical treatment. Although law professors and economists have frequently suggested that health care providers and consumers should enter into contracts creating rights and remedies that differ substantially from those established by courts and legislatures, this way of attacking the problem has remained largely an academic idea. The time has now come, it seems to me, for the health care industry, and ultimately the courts, to recognize that tort law as laid down by courts and legislatures is not necessarily the final word. Instead, tort law should be seen as governing only in the absence of a negotiated arrangement. Although questions may be raised about the enforceability of particular contracts altering patients' rights, it seems to me that courts should be generally receptive to private parties' efforts to escape the burdens imposed upon them by existing law.

In this statement, I will first show how changed industry conditions have made it feasible and acceptable to contemplate private initiatives to redefine rights and responsibilities associated with medical accidents. Then I will summarize some reasons for thinking that the legal system has not found the best, or even a satisfactory, way to protect consumers against the risk of injury and to motivate providers to provide care of appropriate quality. Finally, I will suggest some ways in which health care providers and consumers might improve upon the legal system's effort.

Courts should certainly hesitate before enforcing a liability-limiting contract that a patient -- usually with the benefit of hindsight following some injury -- later regrets having entered into. Nevertheless, they should avoid being too hard to convince that such a contract was fairly negotiated and served the interests of consumers as well as providers. Because the new competitive environment gives consumers new opportunities for informed choice of health plans and providers and new help in bargaining with provider interests, the need for judicial vigilance against provider overreaching is lessened. I have argued in a recent article that courts should have an open mind when they are asked to enforce a private contract that purports to alter the liability rules prevailing between health care providers and their patients. Havighurst, "Decentralized Decision Making: Private Contract Versus Professional Norms," in J. Meyer, ed., Market Reforms in Health Care ch. 2 (American Enterprise Institute for Public Policy Research, 1983). A copy of this article has been submitted for the hearing record.

I. THE APPEARANCE OF COMPETITION IN THE HEALTH CARE INDUSTRY HAS CREATED NEW OPPORTUNITIES FOR CONSUMERS TO ESCAPE THE LEGAL SYSTEM'S MONOPOLY OVER THE MAKING AND ADMINISTRATION OF LIABILITY RULES.

More than anything else, the appearance of active competition in the health care sector is the circumstance that makes it possible now to contemplate private solutions to the problems posed by tort law for medical care providers and their patients. In the era when the current law of medical malpractice took shape, consumers were seen as having no real options in the marketplace and no capacity to exercise choice. It was therefore natural for the law to prescribe duties and for courts to be suspicious of attempts to set aside the law's prescriptions. Under the old assumptions, it was also natural for the law to look to the medical community for standards of care and to enforce professional norms of conduct without questioning their appropriateness or cost-effectiveness. Under the old circumstances, tort law was essentially prescriptive and regulatory, imposing substantial sanctions for departures from accepted processes whenever a bad result occurred.

The old situation was, of course, essentially monopolistic. Health care was generally thought of as the product of a unitary "system" in which consumers had little choice, professionals set their own standards, third-party payers unquestioningly supported professional habits, and tort law rigorously enforced adherence to the system's norms. Recently, however, profound changes have begun to occur both in the structure of the industry and in our ways of thinking about health care. As we have begun to recognize that we live in an era of limits, even for medical care, alternatives to the previously dominant style and methods of practice have begun to seem acceptable. Although it is still hard to acknowledge it explicitly, we are gradually accepting the fact that we can't have it all, that the highest quality is not necessarily worth its high cost, and that trade-offs must be made. The belief that the same high standards should prevail everywhere, though still widely professed, is more and more seen as unrealistic, and emphasis is being placed instead on raising standards where they are unacceptably low. Decisionmaking is being decentralized, thus opening up innovation possibilities that were previously foreclosed.

In these new circumstances, there is less reason to assume that there is one right way to treat patients. It should also appear that there may be more than one right way to redress medical injuries. Now that we have accepted alternatives to the dominant system of medical care, it seems a logical next step to look to HMOs and competitive medical plans of other kinds to offer consumers alternatives to the dominant legal system. Indeed, the key benefit of deregulating the health care industry, which more than compensates for the accompanying problems, is that it offers consumers a chance finally to escape the burdens of professional monopoly -- not only the physicians' monopoly over the making of costly medical decisions but also the lawyers' monopoly over the costly business of making and administering rules governing liability for medical injury.

II. THE EXISTING LEGAL SYSTEM IS VERY COSTLY, PROVIDES POOR PROTECTION FOR PATIENTS, AND MAY DISTORT INDUSTRY PERFORMANCE.

There are not many good things that can be said about the existing legal system for handling medical malpractice. Its most apparent virtue is that it gives patients an opportunity they would otherwise lack to call doctors and hospitals to account for harms they cause through poor practice, and it is at least arguable that the availability of this powerful grievance mechanism causes health care providers to be more careful than they would otherwise be and more attentive to their patients as human beings. Although the coming of competition has given consumers more opportunities for choice and effective complaint that they previously enjoyed, there may still be a need for some public forum in which a patient can pursue his grievance to a decisive result and can see a meaningful sanction imposed on a negligent provider. Almost certainly, the reluctance of legislatures to make substantial changes in the law of medical malpractice has been attributable to a sense that patients should not be deprived of this basic right to seek redress for the serious harms that providers do, sometimes through culpable neglect.

Everything else that can be said about the law governing medical malpractice is negative. The following brief specification of the legal system's faults, summarizing what others have observed, adds up to a powerful indictment. Although these objections may not justify legislation repealing or greatly restricting patients' right to sue, they certainly suggest that both providers and patients could benefit substantially by entering into private contracts creating liability rules which differ from the rules created and administered by the legal system.

(1) Very high legal and administrative costs. Judging negligence in the provision of medical care is often very difficult and expensive. As a result, much of the money paid as malpractice insurance premiums is absorbed, not in paying claims, but in deciding whether a particular loss should be shifted. Estimates of the portion of the premiums paid into the system that eventually goes to injured persons go no higher than 40 percent, meaning that at least 60 percent of the premiums collected go to pay lawyers and insurers for operating the system. (Costs of operating the courts are an additional and hardly negligible factor.) It might easily be judged that these high operating costs are not justified by any benefits the system yields in overcoming economic hardships and enforcing good medical practice. A system of compensation that was simpler to administer -- that did not, for example, require a determination of fault in every case -- could benefit many more injured patients without costing any more. Patients and providers might see an opportunity to cut out the lawyers and to use the savings to cover more injuries, to reduce fees or premiums, or to improve quality.

(2) High psychic costs. The emotional toll taken on both providers and patients is unmeasurable but is very high. The acrimony of trials, the tensions introduced into doctor-patient relationships, and the burdens on patients awaiting adjudication of their claims have been remarked by many others. Many, though perhaps not all, individual providers and patients will see substantial value in escaping from such a system into one with fewer adversarial features.

(3) The haphazard incidence of compensation. Many injured patients go uncompensated even when their injuries were actually caused by negligence; a few patients are compensated extravagantly. A review of the numerous reasons why some potential lawsuits are brought while many others are not leaves the impression that the system is not serving any clear function well. Instead, like lightning, it seems to strike almost at random. There would seem to be a great deal of room for improving patients' financial security by increasing the number of patients compensated while reducing the level of payment to more closely approximate real economic losses.

(4) Perverse incentives. Although the tort system is expensive to administer, there is always the possibility that its cost is justified by the behavior it induces. But there is good reason to believe that the liability system, whatever good it does, also promotes a great deal of uneconomic and undesirable behavior. Although "defensive medicine" is difficult to define and identify, unnecessary testing and overutilization of health care resources do occur and seem in some degree to reflect providers' desire to be protected against accusations of negligence. Moreover, tort law enforces a standard of care drawn primarily from customary practice -- did the doctor do what other doctors would do? Unfortunately, this

standard of care is almost certainly an inefficient standard because it is derived by observing a market in which third-party payers unquestioningly foot the bills and physicians seek not only absolute safety for their patients but also protection against lawsuits for themselves. By using customary practice as a reference point for imposing liability, the legal system appears to restrict opportunities for even the most responsible economizing, thus forcing the public to bear unnecessarily high health care costs. Private agreements altering liability rules would seem to have great potential for improving the climate for efficient behavior.

III. THERE ARE NUMEROUS WAYS IN WHICH PRIVATE CONTRACTS BETWEEN PROVIDERS AND PATIENTS COULD IMPROVE UPON THE EXISTING LEGAL SYSTEM.

Although the foregoing defects in the existing legal system are hard to compare to any benefits that the system may have in raising the quality of care to appropriate levels, they certainly provide a solid basis for thinking that there is room for improvement. Because legislative changes are inhibited by interest-group politics and uncertainty about precisely what to do, private avenues of change are worth exploring. Providers and consumers interacting in a competitive market would appear to have an excellent opportunity to negotiate new arrangements that, by avoiding heavy legal and administrative costs and lifting the heavy penalties on responsible cost containment, could benefit everyone directly concerned. Only trial lawyers would have reason for complaint. Even patients who later suffer some injury that would have entitled them to a huge award may be seen as beneficiaries of the earlier decision to rule out such recoveries.

The following paragraphs suggest some specific ways in which private health care plans and individual hospitals and physicians might agree with consumers on a different set of rules governing what happens when a patient suffers an injury in the course of treatment:

(1) Changing the forum. HMOs in California have already been allowed to require arbitration of claims for medical malpractice. Such arbitration agreements may be entered into before an injury occurs, and plaintiffs have been held bound by arbitration clauses negotiated by their employers on their behalf even when they did not actually know that their right to a jury trial had been restricted. In such cases, it appeared to be important that the employee also had the option (through "dual choice") of choosing another form of financial protection which would have maintained his traditional legal rights. In addition to arbitration clauses, one can also imagine provisions that would limit the bringing of malpractice suits that have not been previously approved by a screening panel of some kind. Such methods for foreclosing frivolous claims are similar to those adopted in some state legislation and would provide some protection to providers without preventing clearly meritorious actions.

(2) Limiting recoveries. Just as some states have sought to limit malpractice recoveries, private parties might do the same. Although the agreement might set a flat dollar limit, it would probably be preferable to provide that a plaintiff could recover his full economic losses but not for pain and suffering or amounts reimbursed from collateral sources; a possible variation might provide an additional amount out of which the patient could pay his attorney's fees. Even though such limitations on recoveries might appear to benefit only the provider and not the patient, the lesser exposure to liability risks might well translate into lower fees and health plan premiums.

(3) Altering the standard of care. Because malpractice law appears to require that physicians adhere to customary practice in their community, opportunities for responsible economizing are restricted. As a result, a health plan or provider might wish to specify by contract a commitment to abide by a different standard. For example, an HMO might contract to be bound, not by community standards, but by the standards of other HMOs. Alternatively, the HMO's subscriber contract might preserve a right to depart from customary standards in good faith where medical literature supported the HMC's judgment and its subscribers were consulted on the decision to adopt different methods. Avoidance of dubious claims might also be accomplished by contracting to limit liability to those cases in which gross negligence or an intentional act or omission could be proved.

(4) No-fault alternatives. As a substitute for patients' rights under the tort system, a provider or organized health plan might provide for automatic compensation for certain designated compensable events. Some years ago Dr. Laurence Tancredi and I proposed such a no-fault system that would be financed through provider-purchased insurance. See Havighurst & Tancredi, "'Medical Adversity Insurance' -- A No-Fault Approach to Medical Malpractice and Quality Assurance," 613 Insurance Law Journal 69 (February, 1974); see also Havighurst, "'Medical Adversity Insurance' -- Has Its Time Come?," 1975 Duke Law Journal 1233. A study by a commission appointed by the American Bar Association confirmed the desirability and feasibility of such a compensation system. ABA Commission on Medical Professional Liability, Designated Compensable Event System: A Feasibility Study (1979). Although a compensation system along these lines could be created by statute, it might also be implemented by private contract. In addition to protecting patients, such a no-fault compensation system preserves strong incentives to avoid adverse outcomes.

(5) The Moore-Gephardt (O'Connell) strategy. Private contracts might also provide for limitations on malpractice claims that are similar to those currently embodied in H.R. 5400, the Alternative Medical Liability Act introduced by Congressmen Moore and Gephardt. This proposal, embodying ideas first advanced by Professor Jeffrey O'Connell, would permit a provider to foreclose a lawsuit for medical injury by tendering the patient's net economic loss. See O'Connell,

"Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses," 77 Northwestern University Law Review 589 (1982). Whatever the desirability of legislation implementing this promising idea, it is worth recognizing that it might also be implemented privately.

(6) Exculpatory clauses. The most extreme form of private agreement altering patients' rights to compensation for medical negligence is an exculpatory clause, by which the patient entirely surrenders his right to sue. Although clauses of this type have been struck down by the courts from time to time, a case can be made for enforcing them. See Epstein, "Medical Malpractice: The Case for Contract," 1 American Bar Foundation Research Journal 95 (1976). In any event, it should be clear that judicial resistance to enforcing contracts of this extreme type does not control the enforceability of agreements of other kinds.

* * *

Mr. Chairman, these remarks are meant only to highlight some new possibilities for relieving the serious burdens that are imposed on patients and providers alike by medical malpractice and the legal system's current methods for dealing with it. The new competitiveness of the health care industry makes private solutions to this problem thinkable for the first time. I am currently in the process of organizing a major national conference to be held next Winter at which we hope to explore the private sector's potential role in solving these difficult problems. I hope that members of Congress, while continuing to consider the federal government's role in addressing these issues, will share my hopefulness about initiatives in the private sector. Any encouragement that this committee can give to such initiatives would be highly beneficial.

Senator **Quayle**. That would be a great expectation and something that I would certainly encourage and hope that you have some reasonable degree of success.

Next is the associate professor from Wharton School, Arnold Rosoff.

STATEMENT OF ARNOLD J. ROSOFF, J.D., ASSOCIATE PROFESSOR, WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA

Mr. **Rosoff**. Senator, thank you, and I'd like to thank the committee for allowing me to participate in your inquiry and deliberations on a very important issue and one that I think is essential to the public interest.

There are many things that I would like to say, but given the time constraints, I think I'll have to be content to limit myself to just three points, if I can manage even those.

The first point I'd like to make is the question of whether there is a malpractice crisis now. There is some significant evidence that litigation is heating up again. I think we have to be very careful not to overread this evidence or to overreact. There have been repeated predictions over the last several years of a resurgence of the medical malpractice crisis, and there has been an increase in litigation and the number of awards granted to plaintiffs and the size of those awards, but perhaps not of crisis proportions. I think I would agree with Professor Danzon on that point, if I understood her correctly.

I'd like to back up the the earlier crisis, the one of the early 1970's, and read to you and to the audience some of the words of Paul Starr, a noted sociologist. He wrote in 1975:

> A crisis of any kind is a moment of potential discontinuity in social affairs. Simultaneously a danger and an opportunity: the danger to the orderly operation of the social system, but also an opportunity for those who wish to change it in some way. For this reason, crises are not always resisted; on the contrary, they are often welcome. A crisis can be a truly marvelous mechanism for the withdrawal or suspension of established rights and the acquisition and legitimation of new privileges. The power to creat crises and the opportunities they bring—and just as important, the power to define them—are not distributed equally in society.
>
> Some groups are better positioned than others to promote their conception of events and to enlarge their discomforts into social concerns. This is the case with the malpractice crisis. It is the malpractice problems of physicians and insurers, rather than those of patients, that now constitute a crisis.

This is 1975, when he was writing.

> This is a reflection not so much of the relative seriousness of their difficulties, as of their relative power to turn private into public troubles. These two groups, the physicians and insurers, along with the legal profession, dominate the current situation. Within this triad all the terms of debate are set. Whatever the resolution of the current crisis, it will almost certainly have to satisfy the interests of the three dominant parties. Less certainly will it have to satisfy the interests of the public. The public has no clear conception of what its interests are, whereas the three dominant parties—that is, the physicians, insurers, and the legal profession—most emphatically do.

And I think that's still an appropriate caution that Starr would urge here. A crisis can be an occasion to limit the rights of patients who feel they have been improperly treated. If you look at the medical malpractice reform litigation—legislation, rather—of the middle 1970's, a very substantial portion of it was doctors' legislation. It was designed to protect the health care system from this onslaught of malpractice litigation, and I think it's important to recognize that patients 'rights have to be respected, too, in any proposed change.

My second point, along the same lines, is that our current problem—and I do think that there is a problem—is not just too much litigation or too many awards for plaintiffs or too high awards for plaintiffs, but it's the difficulty of plaintiffs getting adequate representation, especially in small dollar cases, and a reasonably prompt resolution of claims. There's a substantial time delay, and established providers and insurance companies can afford to play a waiting game and delay where it's to their advantage, whereas patients who have been injured and have difficulty, loss of wages, loss of job, et cetera, have to cave in after a while.

I think that arbitration and screening panels, which were originally set up in many States to expedite the resolution of malpractice claims, have actually worked in the opposite direction in many cases. They are used by the defendants to delay rather than to expedite. I think there's a tremendous potential that these screening mechanisms have for resolving many of the problems of the system, but we have to look at what States have done. We have to identify best practices, synthesize those best practices, and build on them. I would suggest that if the committee wants to look into any kind of reform measures, it look again—as others have before—at these screening mechanisms or arbitration mechanisms.

My third point, and final, is that we shouldn't lose sight of the quality of care. My two colleagues have already spoken to this to some extent. Threat of malpractice liability is a crude and an imperfect way of fostering quality of care, but many feel that it's an important factor. We shouldn't be too quick to undermine or dilute this safeguard, this essential safeguard of quality until we have confidence in the other safeguards or quality assurance measures.

Had I more time, I would talk some about the prospective payment system and DRG payment for hospitals and how that might negatively impact the quality of care and make all the more important malpractice liability as a potential safeguard of care. But I don't have the time, so I'll refer you to my written comments and hope the committee will take some account of those.

In closing, I would like to say again that I'm very pleased to be here and I would offer my continuing interest and involvement in the committee's activities and deliberations if that's appropriate. Thank you.

[The prepared statement of Mr. Rosoff follows:]

TESTIMONY
OF
ARNOLD J. ROSOFF, J.D.

Mr Chairman and Members of the Committee, I am Arnold J. Rosoff, Associate Professor of Legal Studies and Health Care Systems at the Wharton School of the University of Pennsylvania. I teach, do research, and write in the area of health care law and have been closely involved for more than a decade in Wharton's Graduate Program in Health Care Administration and, more generally, in educating managers for our nation's health care delivery system. I am here today at the Committee's request to help provide some historical background and a contextual framework for your present consideration of problems facing our system for dealing with medical malpractice claims.

I thank you for the opportunity to speak with you and to participate in your consideration of a very important subject. Further, I commend the Committee for undertaking this inquiry. As you know, problems with our nation's medical malpractice system have been a serious concern to health care providers, patients' rights advocates, students of the health care system, and governmental policy makers for well over a decade, rising in the early 1970's to a level widely labelled a "crisis." This so-called crisis spawned not only a national study commission [the HEW Secretary's Commission on Medical Malpractice] but also an extensive outpouring of remedial legislation at the state level. Between the years 1974 and 1977, virtually all of our states studied the problem and many of them enacted correc-tive legislation dealing with one or more of its aspects.

Sadly, it is clear now, almost a decade later, that these various legislative fixes have not been wholly effective. After years of relative quiescence, evidence is mounting that a second wave of the "malpractice crisis" may soon be upon us.

WHY CALL IT A "CRISIS"?

Let me pause for a moment to explain that I am using the term "crisis" here to mean:

(1) a substantial increase in the number of suits being filed and litigated, the number of awards and/or settlements obtained against health care providers, and the size of those awards and settlements; and

(2) a substantial increase in the cost and/or decrease in the availability of medical malpractice liability insurance.

Please note that in applying the term "crisis" to the above conditions, I do not mean to imply that there is anything wrong with recipients of health care services using the legal system to seek just compensation for injuries suffered. Nor do I see it as improper that the number and amount of their recoveries should increase, provided that there is a sound basis in law and fact for those recoveries. Nevertheless, in terms of the stability of the health care system, such changes -- justifiable or not -- still represent a serious problem. If the system, including the underlying malpractice insurance system, cannot adapt to and support such changes, severe effects on the quality, cost and availability of health care will result. In and around 1974, many may recall, one of the manifestations of the crisis was a number of "strikes" by physicians who refused to render medical and surgical services until they were given assurance of reasonable safety from personal liability. Were such strikes to take place again on a widespread basis, the potential for harm to users of our health system would be great. For this reason, one must regard major disruptions of the malpractice system as a crisis regardless of one's personal views about who is "right" and who is "wrong."

PREDICTIONS OF RENEWED CRISIS

Professor William Curran of Harvard, a member of the HEW Malpractice Commission of the early 1970's and long a close observer of the malpractice system, has recently called attention to the dramatic rise in malpractice claims filed in Massachusetts. He reports that that state's joint underwriting group has requested a 162 per cent increase in medical malpractice insurance premiums for 1984 and notes that this is not an isolated phenomenon. His closing observation is that "These figures do not encourage physicians to believe that the crisis in the medical-malpractice field is behind them."[1]

I do not see the signs as encouraging either. Numerous articles in the health care press in the last few years have cited early signs of a resurgence of malpractice litigation.[2] Some have also noted the relative financial weakness of many of the doctor- and hospital-sponsored insurance mechanisms currently in operation.[3] Moreover, a new and significant factor has recently been introduced by the implementation of a prospective payment system (PPS) for inpatient care of Medicare beneficiaries. The central objective of PPS is to give health care providers a financial incentive to serve patients more efficiently and economically. Health industry commentators have predicted that the new incentive structure may induce health care providers to "undertreat" their patients, to cut corners and skimp on quality and, ultimately, to reduce significantly the quality of care that patients receive. It is too early to tell whether such dire predictions are well-founded; but clearly they cannot be dismissed. Decline in the quality of health care, whether actual or merely perceived, will certainly have implications for the number and magnitude of malpractice claims and recoveries.

I believe it is critical for policymakers in both the public and private sectors to heed these early warning signals and take appropriate preventive action. Paul Starr, in a 1975 article entitled "Malpractice: The Doctors' Discomfort"[4], observed that corrective measures adopted at the height of a perceived crisis are not likely to be balanced and even-handed. Thus, it is very timely that this Committee is now considering the malpractice situation even though we are not yet in a state of frank emergency.

LESSONS FROM THE FIRST "CRISIS"

The mass of studies commissioned in the 1970's and the experience since that time with the various malpractice reform measures adopted have much to teach us. I offer here just a few personal observations which I hope will not be overlooked in this present consideration of the malpractice problem and possible responses.

First, the solution to increased malpractice litigation is not simply to make it harder for aggrieved patients to sue and/or recover for their injuries. Starr and others have characterized the remedial measures of the mid-70's as "doctors' legislation"

-- i.e., laws adopted at the instigation and for the benefit of physicians, other health care providers, and their insurers. Such one-sided legislation is not only unfair; it also focuses on the symptoms of the problem without adequately addressing the underlying sickness, deficiencies in the quality of the health care being delivered and the human sensitivity of the system delivering it.

Second, as the HEW Malpractice Commission noted, the deficiencies of the malpractice system in this country run in two directions. Not only are there claims and recoveries which are unjustified, there are also many meritorious malpractice claims that are never pursued because the patients involved cannot secure legal representation. This is especially true of smaller claims where the lawyers' share of the limited recovery possible is too small to make it worthwhile to undertake the representation. A simplified, expedited, and less expensive system for processing such smaller claims -- say, claims under $15,000 -- would be a great contribution to this field.

Third, picking up on a point just made, streamlining and reducing the cost of processing malpractice claims would contribute importantly to containing the overall cost of health services. An HEW symposium on medical malpractice conducted in the early 1970's reported that 86 per cent of premiums paid for malpractice liability insurance goes to operate the claims resolution system rather than to pay compensation to injured and deserving parties.[5] Assuming this statistic was accurate when first reported, I doubt that the situation has changed much in the intervening decade and a half. This inefficiency in the system manifests itself not just in excessive amounts going to the wrong parties for the wrong things; it shows up also in excessive time lag before proper compensation can be paid to injured parties. Arbitration systems and pre-trial screening panels -- two of the procedural reforms adopted by several states in the mid-1970's -- have the potential to make the dispute-resolution system not only faster and more efficient but also more accurate. I will discuss these mechanisms more fully later in my testimony, for I believe they deserve careful consideration.

Finally, it should be noted that the tort-based malpractice system has an important role to play in maintaining the quality of care. Despite the inefficiences and perversities of a litigation system, most would concede that, to some degree at least, it does provide a needed incentive to use caution in the provision of care and, from an institution's standpoint, in the monitoring of who is providing care and under what circumstances. As Professor Arthur Southwick of the University of Michigan, among others, has noted, hospitals are increasingly being held responsible by the legal system for the quality of care provided by health professionals who are not directly employed by these institutions.[6] The fear of liability motivates hospitals to act more aggressively in protecting patients served in and through their facilities. I would not care to see malpractice reforms adopted which would significantly blunt this salutary incentive. For this reason, I do not favor the various "no fault" proposals which have been introduced over the years, although I would support mechanisms to assure that adequate and prompt compensation is available to injured patients.

"DEFENSIVE MEDICINE"

An issue frequently raised in connection with the malpractice crisis is the "defensive practice of medicine", that is, the alleged distortion of appropriate treatment of patients to secure greater legal safety for the health care provider. Doctors and hospitals, it is claimed, often perform tests, procedures, etc., not because they are thought to be in the patients' best interest but, rather, because failure to perform them would expose the providers to greater risk of being held liable. It is further claimed that health care costs are substantially inflated by these additional services which are not medically justified. Doctors often refer to the pressures to practice defensively as a significant factor contributing to excessive costs for health care.

Nor is the cost of unnecessary services the only dimension of the problem. It is also claimed that some of the tests and procedures which are motivated by malpractice concerns are potentially harmful or involve undue risk to patients. Further, it is noted that, under fear of liability, doctors may refrain from performing procedures they feel are advisable because those procedures carry too great a risk of legal harm if a good result is not obtained. Thus, defensive medicine may show up as "undertreatment" as well as "over-treatment."

That the defensive practice phenomenon exists seems clear beyond question. However, the extent of the problem is much less easy to assess. On several occasions, noted researchers have attempted to identify and quantify the impact of defensive medicine; but their results have been largely inconclusive. Careful study of a given case may reveal the presence of defensive medical practice, but the kind of close review needed to make such a determination is a powerful deterrent to studies involving large volumes of cases. Studies which attempt to survey physicians and rely on their perceptions as to whether defensive practice is widespread encounter the following problem: physicians readily express their belief that their colleagues practice defensively but assert that, for themselves, they would never take actions they do not deem medically indicated and in their patients' best interest. Thus doctors are saying that the problem exists, but only in other doctors' practices, not in their own.

"Defensive medicine" is an important problem; the difficulty of studying it does not take away from that. I would like to see substantial, sound research done on this. Perhaps some of the work which will be done to assess the impact of PPS and other new incentives for cost containment in health care will yield some valuable insights into the effect of liability risks too.

SOME THOUGHTS ON MALPRACTICE REFORMS

Once this Committee determines to its satisfaction the nature and extent of the medical malpractice problem(s), it will likely want to turn its attention to possible solutions. Some remedial legislation -- e.g., H.R. 5400, introduced earlier this year by Congressmen Moore and Gephardt -- already is receiving widespread consideration. Without speaking directly to this bill or any other pending legislation, I would like to register a few thoughts of my own regarding possible malpractice reforms.

For one thing, to repeat an earlier point I consider most important, reform should not be approached from the simplistic objective of making it more difficult for patients to sue health care providers or putting limits upon their recoveries. The legal system must be accessible and responsive to the needs of injured parties, health care consumers no less than others.

Second, any system for dealing with malpractice claims should provide for an effective tie-in to professional and institutional licensure and discipline mechanisms. A major shortcoming of fault-based tort law systems from the standpoint of quality assurance is that they have their primary impact after-the-fact. That is, they provide compensation to injured parties after the harm is done. Where life and health are at stake, that is clearly not sufficient. Some mechanism is needed to monitor and assure quality before harm occurs. Many states in recent years have improved their professional licensure and discipline systems, but there is still room for improvement in the way these systems are linked to the malpractice litigation system. Refinement of these linkages is a worthwhile objective of the current inquiry.

Finally, as mentioned above, I believe in alternative dispute resolution systems, such as arbitration and pretrial review panels (PRPs), for malpractice claims. The technical complexity of many of the issues makes it difficult to get satisfactory resolution from a traditional jury trial. Even if one has faith in the jury's ability to ultimately reach the "right answer", the system still is cumbersome, slow, expensive, and too subject to "gaming." Juries have their place in our legal system -- a place that is guaranteed by the constitutions of most states -- and I am not proposing their complete exclusion from the medical malpractice field. I do feel, however, that there is a need for mechanisms which can preview cases, weed out clearly meritless claims, foster early settlement of clearly meritorious claims, and help to assemble information and clarify issues before trial. Some states -- e.g., Wisconsin, Hawaii, and Massachusetts -- have reported substantial success with such mechanisms. Other states have not been so lucky, but there is reason to believe that their problems stem from faulty design and/or implementation of their systems.

In 1980, a consortium of academic and professional groups with which I was involved proposed to the Department of Justice a comprehensive and carefully developed study of pretrial review panels (PRPs) for medical malpractice claims.[7] Sadly, that study, although it was generally well received within DOJ, fell prey to departmental budget cuts and was never undertaken. The subject matter is even more timely now than it was then, and it would be well for this Committee to consider studies of this type as one aspect of the search for solutions to the malpractice problem.

IS THERE A FEDERAL ROLE?

Since medical malpractice has long been a matter primarily of state law, and since health care professionals and institutions are licensed at the state level, one might question whether there is a federal role in this area. In my view, it is clear that federal involvement is not only appropriate but necessary. For one thing, more than a third of the health care in this country is provided under programs which are either wholly or partly federal and is paid for largely with federal dollars. The federal government has assumed major financial responsibility for the health care of the more than 28 million Americans covered by Medicare and, in many ways, has undertaken the responsibility for assuring that that care is of adequate quality. Thus, both the cost and the quality of health care for the beneficiaries identified above is a federal concern.

Beyond that, the impact of health care on the nation's economy and on the general well-being of its citizens is so great that it cannot be left entirely to the states. A malpractice "crisis" would not touch just one or a few isolated areas of the country; it would have effects from coast to coast, potentially reaching every American citizen.

Moreover, past experience has shown that the states' responses to this problem may be highly variable. The ability to conduct social experimentation on a state-by-state basis may be a valuable feature of our federal system; but it has its ultimate limitations. There must be some overall coordination of what is done at the state level, assessing the successes and the failures of the states' experiments and pointing the way toward a synthesis of "best practices." No state has either the interest or the resources to undertake such a broad leadership role; it is a role that is, by its very nature, uniquely federal. I do not advocate -- let me be clear -- a federal preemption in the area of medical malpractice. But I do believe that the federal government should play a key role in the definition of the problem and the search for solution(s).

For the above reasons, I am gratified that this influential Committee has seen fit to concern itself with the issues of medical malpractice, the maintenance of the quality of health care, and the rights of our citizens when they assume the role of consumers of health services. I am pleased and proud to be a part of this activity and would like to be of whatever service I can as the Committee's work on this subject proceeds.

In stating my interest and willingness to participate, I know that I can speak also for two national organizations of which I am a member: the American Society of Law and Medicine, which has recently assembled a work group on the subject of medical malpractice, and the American College of Legal Medicine, the Research Committee of which was closely involved with me in the development of the PRP study I mentioned earlier. Both of these organizations have a strong interest in the subject of medical malpractice and would welcome the opportunity to have further input into this Committee's deliberations and any subsequent activity to which they might lead.

Thank you once again for inviting me to be with you today.

* * * * *

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Senator QUAYLE. It certainly will be appropriate and we thank you for your testimony. Your full statement will obviously be in the record, and we may get into discussion in questions and answers on the DRG system and prospective reimbursement if in fact you want to emphasize that point of medical malpractice being somewhat of a safeguard for that.

The final member of this first panel, associate professor, School of Law, University of Detroit, Barry F. Furrow.

STATEMENT OF BARRY F. FURROW, J.D., ASSOCIATE PROFESSOR, SCHOOL OF LAW, UNIVERSITY OF DETROIT

Mr. FURROW. Thank you, Senator.

I'm a law professor, teaching primarily torts and health law. I'm also editor-in-chief of the Journal of Law and Medicine in Health Care, and for purposes of this hearing, I suppose most importantly, I am chairman on the task force on the relationship between cost limitations and standards of care, a task force sponsored by the American Society of Law and Medicine. We're currently engaged in evaluating reimbursement policy, particularly DRG's and prospective payment mechanisms and their relationship to tort law. My statement today, however, does not represent a consensus statement of that task force, which is currently studying this particular problem.

As the last speaker in the panel it seems to be fair to summarize and say that we're all in agreement that quality of care is a central concern. I'm going to take a somewhat harder position. I'm going to say that the current tort system has significant value as it stands as a quality control mechanism, and I support that with six general observations which have some support in the research literature.

No. 1, doctors and hospitals are better able than patients to control and reduce malpractice risks and losses.

No. 2, medical peer review and professional self-regulation has proved largely ineffective.

No. 3, malpractice claims strike physicians in a predictable fashion rather than a random fashion.

No. 4, the number of malpractice claims brought falls far short of the number of malpractice incidents which actually occur, for a number of reasons which have to do with the costliness of litigating small claims, the fact that many incidents aren't recognized as malpractice, and so on. My colleague, Professor Danzon, has studied many of these factors and articulated them very well in her writings.

No. 5, "defensive medicine," in my view, may well exist but it has not been proved as a problem. It has no negative implications at present for the tort system as a culprit. Reimbursement policy has undoubtedly been the largest force in generating diagnostic costs and extra testing, which may be viewed as "defensive" in nature but may simply be a response to reimbursement policy. And if one purpose of litigation is to change medical practices in positive directions, then it seems to me that "defensive medicine," if it is a change, may very well be a positive change. I think the burden of proof is upon those who focus on "defensive medicine" as a problem to show that it is in fact not a plus, rather than a minus. It may mean only that physicians are anxious about being sued. That anxiety, in itself, is not sufficient to reform the current system in major ways.

No. 6, there is some evidence to suggest that the tort system as a quality control and a kind of technology assessment works, although it doesn't work perfectly. Far from it. Professor Danzon has estimated that the current incidence of injury is roughly 10-percent lower than would have occurred without tort litigation, and that figure is extremely fluid and hard to establish. In fact, it's largely intuitive, I suspect. But there is some evidence to support it.

There is certainly evidence that an improved level of disclosure of risks to patients has been the result of tort litigation and tort rules, such as the informed consent doctrine. Clearly, hospitals are more sensitive to iatrogenic events within the hospital, at least in part as a result of fear of liability exposure. And I think that closer monitoring of excessive patterns of hospitalization and drug use has been a response to fear of litigation.

So as a quality control system, there is some evidence that tort litigation works. It's a crude device; it has problems as a compensation mechanism, but as a quality control device, it has a great deal of value. In my estimation the tort system needs more study and fine tuning rather than being scrapped, and a theory of medical errors, their causes and their cure, needs to be developed with data to support that theory.

There are two sources of medical injury that deserve more study: medical innovation, the problems of diffusion of medical technologies before they are proven; and, number two, the hospital as a source of injury to patients. There is some study that's going on—two excellent studies in 1981 in the New England Journal of Medicine, and I think we need a great deal more study of problems and how we might deal with them without reforming the system in a drastic way.

In summary, Professor Danzon's suggestions for a cap on awards for elimination of the collateral source rule, some of her specific recommendations make a great deal of sense in reducing the inefficiencies and inequities of the current tort system. Professor Rosoff's suggestions of arbitration, pretrial screening, mediation deserve study. They streamline the dispute resolution process and they may well lead to better, quicker compensation for patients.

Measures such as the Moore-Gephardt bill, in my estimation, do too much too fast and could be a very costly disaster. Insofar as that piece of legislation in particular divorces compensation from quality control, that is a critical flaw.

The Federal role, in my estimation, in summary, should be at best to fine-tune the current system, to study the problem of "defensive medicine" which has yet to be established, in my estimation, and at the bottom line I am skeptical of any major role for the Federal Government. I am skeptical of any drastic reform; I would be in favor of reforms which improve, to some extent, the pay-out for small claims, and perhaps provide free-market options for patients.

Thank you.

[The prepared statement of Mr. Furrow follows:]

TESTIMONY AND MATERIALS

presented to

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

98th Congress, Second Session

July 10, 1984

by

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BETWEEN COST LIMITATIONS AND STANDARDS OF CARE

of the

AMERICAN SOCIETY OF LAW & MEDICINE

The views expressed in this paper are solely those of the author, and do not represent a statement of the American Society of Law & Medicine or the Task Force. The Task Force is currently engaged in evaluating legislative proposals for malpractice reform, and will present its specific recommendations in the near future.

MEDICAL ERROR AND MEDICAL MALPRACTICE:

Litigation as Technology Assessment

by Barry R. Furrow*

Abstract

The practice of modern medicine is being transformed by powerful forces -- medical technologies, new institutional structures, changing modes of reimbursement.[1] Each can claim an important impact on medical practice.[1a] Medical malpractice litigation is another such transforming force promoting changes in medical practice. The goal of this paper is to briefly trace some transforming forces on medical practice, develop categories of medical errors, and then analyze the inner workings of tort doctrine as a quality control and technology assessment mechanism. Technological medicine creates "zones of transition",[2] which present difficult problems for practitioners and for tort litigation. Malpractice litigation can provide a channeling mechanism to stabilize medical standards of practice in beneficial ways.

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Introduction

Discussions of professional regulation tend to downplay the role of malpractice litigation, portraying it as useful only for the sanctioning of gross violations of professional norms. In fact, such litigation should be viewed as a form of microregulation of undesirable practices, with substantial positive benefits -- improved medical disclosure of risks to patients,[3] increased hospital sensitivity to iatrogenic events,[4] closer monitoring of drug use. The impact of malpractice litigation on the behavior of medical professionals has been the subject of much debate among economists,[5] lawyers and doctors, but some general conclusions have emerged.

1. Tort liability is first of all a system of quality control, and it creates significant incentives for reduction of bad medical practices. One recent analysis concluded, with regard to incentives provided by malpractice suits:

> ... it is not implausible that the current non-trivial incidence of injury due to negligence would be at least 10% higher, were it not for the incentives for injury prevention, created by the one in ten incidents of malpractice that result in a claim. If so, the malpractice system, despite its costs, is worth retaining. 6

Compensation is a secondary systemic goal, since it can be achieved more effectively and at lower cost through other mechanisms.[7]

2. Doctors and hospitals are better able than their patients to reduce malpractice losses.[7a]

3. Most extreme criticisms of the system are unfounded, and in fact, the number of malpractice claims falls far short of the number of incidents of malpractice.[8] The data does not reveal the existence of a malpractice crisis. In fact, as one commentator has observed, "only very recently have malpractice insurance costs become large enough to be interesting."[9] The current system may provide significant incentives for changes in medical practice. As one economist has noted:

> A finding that malpractice premiums are being shifted and that defensive medicine is being practiced is not damning evidence against the system. Indeed, one purpose of a tort system is to change the way medicine is practiced. 10

Liability insurance may in fact provide too much insulation to physicians from the deterrent impact of sanctions.[11]

4. It is not evident from the data that claims strike physicians like lightning, unpredictably and randomly. To the contrary, one study concluded that " ... claims are far from random. Past claim history is as good a predictor of future claim experience as medical specialty."[12]

5. Peer review as a means of controlling negligent medical practice is not likely to be effective.[13] Malpractice litigation therefore has a significant and productive function in assuring quality control.

Discussions of medical malpractice have often ended up at either of two extremes: the trial lawyer's view that injured patients deserve compensation, with the treating physician the best source; and the physician's view that such suits unfairly penalize judgmental errors while raising the costs of practicing medicine. The economist's viewpoint -- that from a quality control perspective malpractice suits are useful -- draws our attention to the central issue. How do the inner workings of tort doctrine affect or reduce the level of various medical errors? Can we improve tort rules to better promote litigation to reduce medical errors, particularly those that are responsible for the large share of injuries? Can we reorient litigation theories away from the individual physician to the hospital, the product supplier, or the health care institution, where errors are traceable to the culpability of the latter?

I. Medical Errors: Refining the Tort Standard of Care

Iatrogenesis, defined as the undesirable side-effects of medical interventions, is not a new phenomenon. The major study undertaken by the Department of Health, Education and Welfare in 1973 noted that a substantial percentage of adverse medical outcomes occur as the result of treatment.[14] Others have concluded that many surgical deaths are avoidable.[15] Two recent studies in the New England Journal of Medicine focused upon surgical mishaps in one case[16] and iatrogenic illness in a general medical service at a university hospital in the second.[17]

The first study, surveying avoidable adverse outcomes from colonic surgery, concluded that "[t]he penalties for such misadventures turned out to be severe, with 10 times the mortality, seven times the average cost, and four times the length of hospitalization expected in average patients undergoing comparable but uncomplicated colonic surgical procedures."[18] Of 56 types of errors which occurred, 31 were "those of unnecessary, contra-indicated, or technically defective surgical activity."[19] Other sources of the medical "errors" were identified by the authors, admittedly in an impressionistic fashion, as misplaced optimism, a sense of unwarranted urgency, the urge for perfection, and the use of vogue therapies: all errors of commission.[20]

The second study, of general medical services at a university hospital, monitored 815 patients during a five month period in 1979.[21] Of these, 290 (36 percent) had one or more iatrogenic illnesses, 76 (9 percent) had major complications, and of the 15 who died (2 percent of all patients and more than 5 percent of those with complications), iatrogenic illness was believed to be a contributing cause. The intervention categories were drugs, diagnostic and therapeutic procedures, and miscellaneous others. The authors' overall conclusion was that "the risk incurred during hospitalization is not trivial" and that "the risk of a serious problem may well have increased" in the last 20 years.[22] Causes mentioned included routine monitoring of a range of physiologic characteristics, often leading to earlier interventions than might have occurred in the past, use of a wide range of potent drugs; and the therapeutic procedures in general.[23]

These recent studies, and other evidence point to a level of iatrogenic harms far in excess of the number of claims filed. Medical errors result in patient harm, and the level of patient harm demonstrated by these recent studies raises the question of the interaction of malpractice litigation with risk reduction. Tort litigation can be a central force in promoting change. An analysis of types of medical errors may suggest possible alterations in tort doctrine to better deal with iatrogenesis. Tort rules have traditionally attempted to render the plaintiff whole, after he has suffered injury at the hands of another, by forcing the defendant to pay compensation. This is justified on the principle that the defendant can in fairness be taxed because of his "fault." Malpractice, as applied to professional tort liability, has come to mean that category of acts or ommissions that are "faulty" or negligent.

A. Physician-Fault -- the Negligence Standard.[24]

Traditionally negligence suits have been brought against the physician who has diagnosed or treated the plaintiff, with the issue being whether his conduct deviated from the professional standard of practice within his specialty. Normally, in a negligence suit, a defendant can present evidence of a "customary practice" which he claims to have followed in the particular case. The trier of fact is free to accept or reject this standard, finding the defendant liable in spite of evidence that he followed a customary practice.[25] In malpractice cases, however, the customary practice of the profession determines the standard of care against which an individual's behavior would be judged, "what is customary and usual in the profession."[26] The trier of fact will not be allowed to reject the customary practice as improper. The medical profession therefore has the privilege of setting its own standard of conduct merely by adopting and acknowledging its own treatment practices.[27] The justification for this has been the courts' perceived lack of expertise in judging another profession, and their fear of imposing liability based upon an uneducated judgment. Even if the customary medical practice is inadequate, dangerous, or out-of-date, the plaintiff has lacked a doctrinal basis for attacking the standard itself. The standard is thus proved by evidence of actual patterns of medical practice without any normative evaluation as to whether the existing practice is either effective or useful. One critic of the customary practice standard has observed:

> The controlling standard thus would be defined exclusively in terms of medical procedures that have occurred with sufficient regularity in the past to become unmistakably etched into the practice of the profession. This raises the spectre of the past elevated to prologue in the scientifically dynamic and fluid field of medicine ... 28

The suggestion has been made that the standard should be "accepted practice" in lieu of customary practice, thus allowing practices which are approved by the leaders of the profession, even if not customarily followed. This model would thus allow for evaluation of a standard by reference to the state of the art in diagnosis and treatment. Thus, even without historical antecedents, conduct might be evaluated as sound professional practice, looking to current medical literature. An expert witness could then testify about the best practice.[29]

Two exceptions to the general rule as to proof of the standard of care bridge the gap between the traditional "customary practice" test and the accepted practice proposal of King. First, the "respectable minority" rule allows for variation in clinical judgment, holding that "a physician does not incur liability merely by electing to pursue one of several recognized courses of treatment."[30] So long as the patient is informed of treatment alternatives in compliance with informed consent requirements, the physician is protected. Defendant's distinctive practices must be supported by at least a respectable minority within the professional group if the judge is to be willing to direct a verdict rather than leave the question for the jury to resolve based upon the conflicting testimony of the proponents of the two opinions.[31]

The "best judgment" rule has been allowed in some cases, postulating that "a physician must act in a manner consistent with his best judgment."[32] Clearly, the defendant must be able to articulate a reasoned defense of the treatment decision made in order to convince the trier of fact to override the standard of care.

On rare occasions, courts have even recognized that a customary medical practice may be negligent. Thus in Helling v. Carey,[33] the Washington Supreme Court held that the defendant opthalmologists were negligent as a matter of law in failing to administer a simple glaucoma test, despite uncontradicted expert testimony that it was universal practice not to so test patients under the age of 40.

Helling, and a few other cases,[34] have involved a therapy or diagnostic procedure which was readily understandable by lay persons. This has allowed the trier of fact to weigh - without expert testimony - the relative risk of injury caused by the procedure and by its omission. These cases have not been followed by most jurisdictions, since courts are normally reluctant to set their own standards of care in place of those established by the profession, especially in complex cases. However, courts may be willing to take a hard look at the customary practice where a plaintiff can produce some evidence that the practice is out-of-date or ineffective and thereby dangerous.

A physician may fail to follow an accepted or customary standard of medical practice for several reasons: inattentiveness on a particular occasion, even though she is a skillful, well-trained doctor; a failure of medical education or training, in which a physician has not kept up with her field;[35] a personal inability of the physician to deal with this particular problem, by operating outside of her sphere of competence. The tort system holds a physician accountable for intentional or negligent deviations from medical practice, whatever the excuse. These errors imply that the physician has failed to conduct herself at that level of practice with her professional membership indicates she should have achieved, with due diligence. This category of medical error is thus measured by the benchmark of a profession-wide standard, focusing upon the individual practitioner and her deviation from accepted professional practice. The types of error likely to be detected are those of the unethical or slipshod doctor, who is probably a cause of a small, although significant, percentage of harm to patients. The concern of the cases has often been with a practitioner who had not kept up, or a professional standard which was not up to current research findings.

B. Professional Shortcomings

Deficiencies within a medical specialty may cause iatrogenic harm. These may include problems of scientific ignorance, inadequate evaluation of diagnostic instruments and procedures before use, or failures to educate members. A medical specialty may be in its infancy, so that knowledge about etiologies of illness and techniques of treatment is incomplete. Those therapeutic techniques which are available may not yet have been sufficiently perfected to eliminate substantial risks of side effects.

Although injury to a patient may be caused by the shortcomings of a particular therapist in a given case, it is not the individual's failure, but rather that of the profession as a whole, which can fairly be said to have caused injury. We single out the individual physician for liability, but it is really a mirror image of vicarious liability we are imposing, in which the profession is collectively at fault, but a particular therapist is being penalized for collective shortcomings.[36] The causes cited by the studies suggest that errors in this category (e.g., vogue therapies, multiple drug administration) account for a significant percentage of the iatrogenic harms suffered.[37]

Where medical errors are related to professional shortcomings -- too rapid diffusion of vogue treatments, excessive reliance on unproven diagnostics -- we need to ask how we can fine tune tort standards and proof in order to reduce the error rate. Four possible effects of a tort standard are possible, and the choice of one over another depends on our perception of which sources of medical error are dominant.

1. Standard-neutral. This is closest to the present customary practice standard. The tort standard is simply a mirror for whatever the profession does, as a statistical matter, most of the time. This position of neutrality, as discussed above, means that the profession is dominant in setting standards, and has a shield available for any practitioner who follows the practice, without regard to its effectiveness.

2. Standard-forcing. This operates at two levels. First, courts have on rare occasions set the appropriate standard of practice, in spite of evidence that customary practice is either to the contrary or is less demanding. Helling v. Carey is the best illustration of such rare judicial attempts to force the level of practice higher. Second, where a new speciality is emerging, such as genetic counseling, for example, the lack of a consensus standard means that some defendants will be found liable because they were unable to justify their practice by reference to general practice. This leads to pressure toward consensus. The process is a complex one, and worries practitioners of new specialities. Concern has been expressed that litigation will drive out new practitioners, and expose others to unmanageable expenses.[38] The litigation process contains its own safeguards, however. Individual plaintiffs must prove their cases, presenting evidence and persuading the trier of fact that they should prevail. To do this, plaintiffs must use expert witnesses. The floodgates of litigation are unlikely to let in more than a trickle of suits against physicians in new specialities such as genetic counseling unless plaintiffs can find experts who will testify that there exist established standards of care for any given treatment or mode of diagnosis. As standards evolve, however, such expertise will certainly be more available to plaintiffs. It is percisely this chain of events that illustrates the indirect pressure of tort litigation: the threat of suits will lead to medical attempts to develop a professional consensus.[38a] Medical self-protection is served in two ways. First, articulation and dissemination of standards will educate those in a new speciality,

so as to minimize negligence through ignorance. Second, defendants can take advantage of the real areas of uncertainty by having experts testify on their own behalf. Collection of data and pressure toward consensus will be encouraged even by scattered litigation, for such suits do not go unobserved but rather are heavily noted in the medicolegal and medical presses. Anxiety levels are raised within the practice of medicine; such anxiety can be productive, if it accelerates efforts by a new specialty toward standards.[39]

3. Standard-freezing. If any deviation from customary professional practice is held to be actionable, without allowance of defensive information by the defendant, then we have a standard-freezing effect, in which an ossified customary practice can remain in effect long past its prime. Exceptions such as the "best judgment" rule, the "respectable minority rule," or "acceptable practice" would be narrowly allowed, if at all. Most courts seem not to fall in this category, since in most jurisdictions some flexibility is built into the standard-setting process through use of the doctrines protecting individual judgment.

4. Standard-diffusing. This approach requires a liberal application of the exceptions to the customary practice doctrine, as well as liberal evidentiary rules allowing use of medical treatises and journals which support defendant's use of newer diagnostic or treatment approaches. Our previous discussion suggests that a standard-diffusing approach should be avoided, since one of the larger sources of iatrogenesis and medical error is too rapid diffusion of questionable techniques into use. A relaxed judicial approach to a physician's defense of a vogue therapy, a standard-diffusing approach is undesirable. A view of malpractice litigation as technology assessment would encourage a hard look at medical innovations, to ensure they have not diffused too rapidly into use.

II. Medical Innovation and Evolving Standards of Care

The physician is the principal decisionmaker regarding the implementation of most medical innovations, as she is the front line agent in diagnosing and treating patients. In developing a taxonomy of medical errors, therefore, it is necessary to develop some understanding of how medicine incorporates innovation, and how tort law treats or should treat these "zones of transition"[40] from one customary practice to another. Diagnostic techniques provide one excellent set of examples to use in testing how innovation should be treated in both medicine and in lawsuits involving the technology. Technology diffusion and swift adoption into practice is fueled by many factors: Medical ethics, the need of a physician to do something in the face of a patient's needs, the value our society places on technology generally, the nature of medical training, reimbursement policies.[41] Findings from research are most important, since there is evidence that most physicians regularly read periodicals in which clinical investigators publish research findings, taking note of apparently promising new approaches to diagnosis or treatment. One critic has observed of these research findings:

> Skepticism of new research findings is appropriate for medical practitioners, but it is not common. Practitioners are faced with pressing problems for which they seek solutions. As investigators present new clinical research findings and expand the limits of knowledge, practitioners receive message. 42

In spite of lack of evidence of efficacy, practitioners receive messages that have fostered rapid adoption of new technologies such as CT scanning, coronary artery surgery and respirator therapy. The data and opinions available to practitioners are often inadequate to evaluate research findings, in that the studies themselves may have significant defects; the studies may lack information as to how to translate limited clinical research findings into practice; the practitioners may not be aware of the unique nature of clinical trials; and finally, practitioners receive little guidance as to how to evaluate later controversy over earlier studies.[43]

A look at a taxonomy of practitioners in the context of medical innovation in diagnosis reveals the relative inflexibility of tort law to deal with the complexities of modern technological medicine. In the last section of the article, we will turn our attention to possible changes so that tort law can operate in tandem and not at cross purposes with medical education and other forces in improving medical practice.

A. A Taxonomy of Medical Practitioners. Medicine increasingly relies upon new techniques and technologies of diagnosis, as doctors clamor for more data. Manufacturers respond with an array of techniques and devices, and clinical researchers suggest new approaches. Technologies such as ultrasound, automated clinical analyzers, and heart monitoring systems are now commonly used, and further advances in diagnostic imaging can be expected during the next decade.[44] This proliferation is understandable, for diagnosis is at the heart of the process of medical care and continues to be a major source of physician error. Data for the period between 1973 and 1980, collected by the St. Paul Companies, the nation's largest medical malpractice insurer, reveal the failure to diagnose was alleged in 25 percent of the cases brought for malpractice.[45] Data from the Department of Health, Education and Welfare for suits between July and October of 1976 reveal that about 25 percent of all claims and about 50 percent of claims against internists and general practitioners alleged diagnostic error, while inadequate testing claims were by far the most numerous for nonsurgical cases.[46]

A physician must utilize new diagnostic technologies as part of his professional obligation to patients. He is "bound to keep abreast of the times."[47] However, the physician's relationship to a standard of practice is considerably more complex than the general statements in the case law suggest. Keeping "abreast of the times" is far too vague a standard when the rate of medical change is accelerating well beyond a level known to a practitioner of even twenty years ago. A physician may fall within one of four categories.

1. The out-of-touch practitioner. He has failed for a variety of reasons to adopt the mainstream standard of care of diagnostic testing. It is an old and recurrent problem in the caselaw.[48] An erroneous diagnosis may be merely an error of judgment for which a physician is not liable; however, where relevant data is not secured by use of standard tests, it may be negligence -- i.e., a breach of the standard of care. As one court said:

> If a physician, as an aid to diagnosis, i.e., his judgment, does not avail himself of the scientific means and facilities open to him for the collection of the best factual data upon which to arrive at his diagnosis, the result is not an error of judgment but negligence in failing to secure an adequate factual basis upon which to support his diagnosis or judgment. 49

A failure to recognize a new standard of medical practice represents the classic malpractice situation. Where the deviation from a standard of care can be shown, recovery is likely if the proper proof is presented. For example, since amniocentesis is now the norm for women over 35, a physician's failure to at least suggest the procedure to the patient may lead to liability if a defective child is subsequently born.[50] The failure of a practitioner to use computers to assist in diagnosis may lead to liability. During the zone of transition between experimental uses of a new technology and its diffusion into widespread use, a physician probably has little risk of liability. Once the diagnostic tool has come into widespread use, however, and costs have dropped, the threat of liability is real.[50a]

2. The reluctant practitioner. He refuses to adopt the applicable standard generally or in a particular case. An example is a doctor who refuses to use, or to recommend to his patient the use of, fetal monitors during labor, when such use has become standard practice. Under the traditional malpractice rule, this deviation from the standard may be conclusive as to liability unless the physician convinces the jury that the general acceptance by his profession of such monitoring is not justified.[51] For example, he could use statistics to show that the efficacy of the procedure is unproven in light of its costs and in terms of increased Caesarean sections. He may thus invoke the "best judgment" rule as a defense - a rule that states that a physician should use his or her own best judgment when the commonplace medical practice is

dangerous.[52] In using this defense, the practitioner will face an uphill battle in most jurisdictions in trying to justify his deviation from the generally accepted standard.

3. The faithful follower. The physician who religiously adopts the current mainstream practice is often following sound practice, acting reasonable in his belief that proper research has been done to justify the new procedure. The mainstream practice usually represents sound practice and the physician is reasonable to assume that proper research has been done to justify the new procedure. However, in three situations, blind adoption of a technology may be inappropriate.

First, the current practice of physicians within the specialty may lag behind improvements suggested by current research findings. Practitioners may not hear about new research findings, thereby failing to adopt valid new technologies. For example, psychotherapists who use Electro Convulsive Therapy (ECT) persist in using bilateral electrode placement, despite evidence that unilateral placement reduces adverse effects, particularly those of memory cognitive malfunctions.[53] An emerging consensus by researchers may not be adopted by practitioners for reasons related to the nature of their practice or because they do not keep up with the literature. In such cases, courts have been willing on occasion to treat compliance with a customary practice as only partial, not conclusive, evidence of the standard of care, where the plaintiff can present evidence as to the emerging consensus.[54]

Second, the mainstream technology, particularly in the diagnostic area, may lead the physican into excessively heavy reliance on the technology for his data, so that he relinquishes his other more traditional clinical and diagnostic checks on error. Faulty lab results may go undetected,[55] or more subtle problems may escape notice because traditional crosschecks have fallen into disuse due to an overreliance on the new device or procedure. Computerized axial tomography (CAT) scanners illustrate this problem.[56] The debate about the CAT scanner has centered on its swift diffusion into mainstream use before its efficacy and costs were properly evaluated. (The scanner became a standard of practice for diagnosing certain brain lesions within four years after its introduction). One report, looking beyond cost, noted that the scanner may even have a detrimental effect on therapy, since its accuracy in detecting brain lesions is high, but not perfect, and so further steps are usually needed to ensure that all lesions are detected. The use of the CAT scanner tends to cut short the diagnostic workup, and, consequently, some treatable lesions may be missed.[57]

Technologies of diagnosis in particular can develop a life of their own. Excessive reliance on the computer, the x-ray machine, the electrocardiograph denies the treating physician access to her own senses. The dependence on diagnostic information from complex, automated devices may be counterbalanced by physician recognition that overreliance upon laboratory tests can lead to liability, where crosschecks are available and are not used.[58]

Third, the mainstream practice may have diffused too quickly into professional use. As the history of gastric freezing of duodenal ulcers illustrates,[59] a technique's adverse effects should be enough to alert the doctor to the hazards of the customary practice. Such evidence may be testified to, if an expert can be found, or the periodicals and treatises may be admissible as evidence, if qualified experts are unavailable.[60] Liability in such a case (where the accessibility of the medical literature is clear and the discussion has reached a certain critical mass) might change the mainstream practice by highlighting the technique which is ineffective or dangerous, and by bringing the new results to the attention of other practitioners. Studies suggest that if negative clinical trial results become available after a medical speciality has adopted a technique, practitioners then learn of these results and gradually abandon the practice.[61] Litigation can be part of the pressures which spur widespread abandonment, underscoring the lack of efficacy or hazards of a mode of diagnosis or treatment.[61a]

4. The innovative physician. This physician wants to use a new procedure or diagnostic device which has not yet been incorporated into the professional standard. She may be liable if the procedure has received little support in the medical literature, and if it does not work properly. Even full disclosure of the experimental nature of the procedure or device to her patients may not protect the physician from liability. Sound policy reasons dictate that full disclosure not be a defense to liability in this area. Use of a new untested procedure or test amounts to an experiment on the patient, and it is preferable to have such experiments conducted by trained researchers in a controlled setting approved

by an Institutional Review Board or a Bio-Safety Committee. Such therapy has been termed "nonvalidated practice," since the primary attribute of the novel practice is " ... lack of suitable validating of [their] safety and efficacy ...".[62] The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, discussing physician innovation, wrote:

> Radically new procedures ... should ... be made the object of formal research at an early stage in order to determine whether they are safe and effective. Thus, it is the responsibility of medical practice committees, for example, to insist that a major innovation be incorporated into a formal research project. 63

The hospital, the most likely locus for innovation, may face liability if unscreened experimental procedures carried out by staff physicians result in injury. As discussed infra, a medical error may thus become the responsibility of a hospital in terms of liability exposure.[64]

Innovation, in the context of the complexity of modern medical practice, properly belongs in a controlled environment. Where sufficient literature is available to suggest that controlled tests have validated the procedure, then a physician's risk of liability is diminished, and the fact that a "respectable minority" within the specialty uses the procedure or device is likely to emerge quickly. This approach encourages a physician to be familiar with the merits of clinical testing, evaluation of results, and research protocols, at the risk of liability in adopting a technique which proves ineffective and dangerous.

B. Work Setting Errors. While solo practice has long been the ideal of medical practice, the movement toward group practice has been inexorable. Group physicians constituted 1.2% of the profession in 1940, 2.6% in 1946, 5.2% in 1959, 12.8% in 1969. By 1975, over 18% of all active physicians practiced in groups of three or more. By 1980, 88,000 physicians worked in groups, or about 25% of the doctors in private practice.[65] Other institutional groupings have also emerged, in which physicians practice together. Health Maintenance Organizations (HMO's) are the largest such new form;[66] emergency centers and surgical centers are two other emerging forms.[67]

The growth of the modern hospital as the locus of medical practice is the second significant force transforming American medicine.[68] Physicians have come to need a hospital connection, leading to a collegial practice operating within hospitals. By 1975, no physician would consider practicing without the resources that hospital affiliation brought, and one in four of the 330,000 active physicians practiced fulltime in a hospital.[69] The hospital industry has been integrated by corporations, so that the industry may end up dominated by "huge health care conglomerates."[70] Almost 80 percent of the incidents that lead to malpractice claims occur in hospitals, reflecting the primacy of the hospital as the locus of most medical practice.[71] The work setting of the hospital provides a context in which "persistent and powerful demands cause the individual to behave in a certain way regardless of his personal qualities."[72] These demands can lead to peer pressure against questioning a colleague's judgment or informing on his errors. Alternatively, the incentive structure can be changed in directions which tend to uncover errors.[73]

Large hospital practice has become standard practice, as the larger hospitals became dominant through the federal health planning process.[74] As the hospitals grow more powerful, hospital administrators also gain in power, developing "... a natural community of interest with staff physicians whose modes of practice utilize sophisticated technologies and justify further institutional expansion."[75] One critic has contended that the investments in such large facilities leads to "rigidifying of medical practice around current patterns of treatment favored by the institution. The practice of medicine at the larger hospitals has set community expectations and medical standards."[76] The "coming of the corporation"[77] has therefore already had significant effects on medical practice. The issue is whether tort rules should yield to this transformation of practice, or seek to control or direct it.

Judicial expansion of malpractice liability, making physicians accountable for a range of medical errors, has run counter to legislative reforms in the malpractice area. Over the past decade, state legislatures responding to the so-called "malpractice crisis" have abrogated or restricted the operation of legal doctrines from res ipsa loquitur to informed consent.[78] But the courts have recognized the centrality of the hospital setting. Thus, hospitals have been subjected to an expansion of the _respondent superior_ doctrine and held responsible for the alleged negligence of physicians practicing within them, even when the physicians were independent contractors.[79] An alternative theory of "corporate negligence" has been based on the premise that a hospital owes its patients a duty to exercise ordinary care in suprevising its staff.[80]

A judicial movement toward strict liability for hospital services, analogous to that which exists for some products, may also be developing. Some hospitals have been held liable for harm caused by medical instruments used in treating patients.[81] Courts have usually distinguished the rendition of professional services from the sale of goods.[82] In recent cases, however, courts have begun to examine the basis for strict liability in the medical context. In Hoven v. Kelble,[83] the Supreme Court of Wisconsin, while rejecting strict liability for medical services, noted the similarity between consumers purchasing products and consumers seeking medical care.

> The typical purchaser of medical services cannot evaluate the quality of care offered because medical services are complex and infrequently bought. The medical care market gives the purchaser little assistance in enabling the purchaser to evaluate what he or she is buying. It is generally the physician - not the patient - who determines the kind of services to be rendered and how often ... The physician is in a better position than the patient to determine and improve the quality of the services, and the patient's reliance on the doctor's skill, care and reputation is perhaps greater than the reliance of the consumer on goods. 84

In Johnson v. Sears, Roebuck & Company,[85] a federal district court held strict liability to be a permissible theory of recovery for defects in mechanical and administrative services in hospitals. The court assumed, without deciding, that strict liability would "not apply to professional medical services by doctors."86 But it reasoned that such an exemption should not apply to "those services which hospitals perform for both doctors and patients," because of the "public interest" in having these services "performed properly."[87]

These cases represent a judicial attempt to link tort liability with the predictability of harmful results and the ability to discover and prevent them. Courts are coming to recognize that hospitals are in the best position to monitor iatrogenic effects traceable to their own services, and that expanded liability provides a substantial incentive to providers to improve risk management programs or to face the bad publicity and increased insurance premiums which litigation brings. Expanded liability may therefore create a generalized pressure to alter the work setting in favor of better recordkeeping, more frequent conferences on adverse outcomes, more consultations, and evaluation of procedures not only for cost, but also for iatrogenic impact.

The tort law concept of foreseeability of harm provides the core justification for a concept of medical culpability which can encompass the three categories of medical errors discussed above. Foreseeability involves a prediction, at a time prior to the occurrence of an injury, of the type of injury that might result from a treatment error, of its severity, and of the probability that such an injury will occur.[88] The use of "foreseeability of harm" as the dominant test of a duty to prevent injury requires the actor either to take precautions or to face liability, where harm is likely to occur and the victim has neither consented to nor can avoid the harm.

The focus of predictability of risk moves us from the individual within a professional group to the capabilities of the group itself, or to the institutional setting, the hospital. Culpability is linked to predictability and to the ability of the profession to alter the level of risk, which it is able to predict.[89]

In each case, the test for foreseeability will be derived from the increased predictive powers of modern medicine, through its new technologies and through the use of statistics. As institutions come to know more precisely the extent of the risks associated with their activities, the ascription of responsibility and culpability becomes possible and fair.[90] Even if a medical provider cannot predict the whole range of risks associated with his service, he is in a better position, compared to the patient, to detect and correct as many as possible. It is a question of the relative advantage of the parties.[91] This point has been noted by others. Paul Starr observes that if a hospital faces liability directly or vicariously for its agents' acts, it will tighten controls over medical practice. "Under corporate management, there is also likely to be close scrutiny of mistakes, if only because of corporate liability for malpractice."[92]

Technology provides the tool for monitoring medical practice within the hospital setting, allowing for ready determination of patterns of unusual patient loss rates, excessive surgery or other suspicious behavior. One hospital administrator is quoted by Starr: "The large conglomerate can purchase and/or develop sophisticated quality-of-care control programs managed by statisticians."[93]

The primacy of the work setting thus becomes more important in reducing medical error, and malpractice can be the spur, if expanding theories of liability place responsibility on the hospital and away from the individual practitioners. The hospital is also in a better position to control too-rapid diffusion of inadequately tested medical innovations. A hospital, through its committees, can regulate practices of treatment and diagnosis.[94]

Conclusion

The physician has up until now been the principal decision-maker regarding the implementation of most medical innovations. Regulatory policies to control the introduction of new technologies are often "all or nothing" propositions; they either prohibit the technology until a high standard of safety is met, as with the Medical Device Amendments to the Food, Drug and Cosmetic Act, or leave control to the informal pressures of the marketplace. Thorough pre-market testing cannot always detect adverse reactions which occur only with the passage of time; malpractice suits thus become an important form of postmarket monitoring of the technology. Such suits, focusing on the practitioner's application of technology in the particular case, can subject the professional standard to the spotlight of evidence pertaining to its efficacy, potentially adverse effects, and its rate of diffusion into mainstream use. As one commentator has written:

> Physicians will inevitably make mistakes, but they should not err for the wrong reasons, such as misplaced reliance on fragmentary information, succumbing to the force of authority rather than depending on the strength of evidence, suspicion of population based studies, ignorance of the pitfalls and requirements for statistically and scientifically valid clinical research, a need to have the latest gadget, a desire to achieve prestige, defend a reputation, or gain financially. 95

Other malpractice developments may also result in alteration of professional attitudes and practices. The doctrine of informed consent, while still bitterly resisted by parts of the medical profession,[96] has had some impact on medical disclosure practices, resulting in more clearly articulated disclosures by physicians of hazards and alternatives.[97] Legal rules, if they are seen as technical and therefore only mechanically applied, are of little use, but when the values inherent in such doctrines as informed consent become internalized, there will be more changes and further reforms.

Malpractice suits have a central role to play in regulating medical errors. Such suits can:

(1) signal the need for change in the habits of the individual practitioner or in the institutional practices of the hospital;

(2) expose the ethical renegades, the Dr. Norks;

(3) provide direct deterrent effects, through dollar judgments and the psychic costs of involvement in litigation;

(4) articulate new duties, validating existing norms or promoting the centrality of new ones;

(5) elaborate new concepts of responsibility, requiring medical specialities to reexamine their diagnostic procedures and treatment modalities;

(6) alter the work setting, spurring better quality control by expanding the liability of institutions which increasingly dominate health care delivery.

Litigation has the advantage of not requiring a new piece of legislation to put its reforms into operation. It can be triggered by a single plaintiff, and once its intervention is sought, a court must act on the case before it.

The recent studies of iatrogenesis suggest that medical errors are a real and substantial problem but that the medical profession still seeks to avoid linking culpability with medical error. Nor is it uncommon to find the legal system blamed for medicine's own tardiness in implementing effective monitoring of iatrogenic harms. Malpractice suits may be the best source of regulation currently available for iatrogenic outcomes in the health care system. Proposals to reform the medical malpractice system will be inadequate if they ignore this primary need to reduce the level of medical error and its negative effects on patients.

The medical establishment needs to be made more aware of the risks it creates. Accordingly, future reforms must note the real problems of medical error and the incentives for correction provided by malpractice litigation. Any "no fault" system, national health insurance plan, or other legislative reforms, must provide an alternative means of deterring iatrogenic outcomes.

NOTES

1. Third party reimbursement practices represent a powerful force converging on medical practice, but one which this article will not discuss in depth. The desire for reimbursement leads to an understandable clamor by subgroups such as nurses and other health professionals as they demand recognition as independent providers. If new allied health professionals are recognized, they are likely to be held to the higher standard of practice of the traditional medical specialities to which they are most related.

The third party payor's listing of approved billable treatments may prove to be a mixed blessing. If a defendant's mode of treatment or diagnosis is on an approved list for purposes of reimbursement, that list

Footnote No. 1 (continued)

may be evidence in defense of propriety of treatment in a particular case; however, such a list may then deny an evidentiary shield to the defendant who uses an effective but unlisted approach, unlisted perhaps because of the expense of that treatment approach. Third-party reimbursement promises a complex and bewildering array of problems.

The most recent change in reimbursement practice comes from new Medicare reimbursement regulations. New prospective payment legislation requires Medicare to fix prices in advance on a cost-per-case basis, using 467 categories called "diagnosis-related groups (DRG's). The hospital is the central instrument of this policy, which promised to complicate treatment decisions in substantial ways. ". . . once physicians begin to encounter this process--reacting to new incentives to reduce lengths of stay, limit laboratory tests, and adopt policies to reduce the use of in patient services--a whole set of other questions arises dealing with quality, access, and appropriateness of treatment. Balancing these conflicting demands will be a tall order." Iglehart, "Medicare Begins Prospective Payment of Hospitals" 308 N. Eng. J. Medicine 1428, 1432 (1983). Physicians are already afraid of increased malpractice exposure as a result of the new Diagnosis Related Groups (DRG) prospective payment

Footnote No. 1 (continued)

system. The AMA in a recent report stated:

> "There is a sense of foreboding . . . because of the anticipated pressure by hospitals to curtail the ordering of diagnostic procedures and shorten hospital lengths of stay. Both could result in increased claims for failure to order medically necessary diagnostic procedures and premature discharge. Reported in Medical Liability Advisory Service, Dec. 1983 at 2.

1a. Ironies abound at the intersection of changes in health care delivery and malpractice. For example, a recent study, comparing the effect of a prepaid group practice (HMO) to free-for-service, concluded that there was much less hospitalization among study participants receiving care in an HMO, than among those with similar benefits who received care from free-for-service physicians:

> " ... GHC physicians were simply practicing a different style of medicine from that of fee-for-service physicians ... the general consistency between our results and those in the literature indicates that a less "hospital intensive" style of medicine than that practiced by the average physician is possible:"

The authors then asked if such a style is desirable?

> " ... prepaid group practices have existed for decades, and it seems unlikely that there can be large deleterious health effects from their style of medicine."

Manning, Leibowitz, Goldberg, Rogers and Newhouse, "A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services," 310 N. Eng. J. Med. 1505, 1509 (1984). The implications for the frequency of malpractice litigation are clear: since hospitals are the locus of most malpractice claims, the spread of prepaid health plans like HMO's will reduce the frequency of malpractice claims by reducing the frequency of hospitalization.

2. This phrase was coined by Bruce Watson in an unpublished paper, "Liability for Failure to Acquire or Use Computers in Medicine (unpublished paper on file with the author).

3. Novack, "Changes in Physicians' Attitudes Toward Telling the Cancer Patient," 241 J.A.M.A. 897 (1979) noting that in 1961, 12% of surveyed physicians generally told a patient about a cancer diagnosis; by 1977, 98 percent reported a general policy of telling the patient.

4. Steel et al, "Iatrogenic Illness on a General Medical Service at a University Hospital," 304 New. Eng. J. Med. 638 (1981). A new speciality within hospital administration, risk management, illustrates this sensitivity.

5. Pocinki, Dogger, Schwartz, The Incidence of Iatrogenic Injuries, in DHEW, Appendix: Report of the Secretary's Commission on Medical Malpractice 50, 51. Schwartz, Komesar, "Doctors, Damages and Deterrence: An Economic View of Medical Malpractice," 298 New Eng. J. Med. 1282 (1978); The Economics of Medical Malpractice CS. Rottenberg, Ed. 1978); Danzon, "An Economic Analysis of the Medical Malpractice System, 1 Beh. Sciences and the Law 39, (1983).

6. Danzon, supra n.5 at 53.

7. Schwartz and Komesar, supra n.5 at 1282.

7a. "The judgment does not imply that doctors' main concerns with avoiding "bad practice" is fear of lawsuits; it implies only that they are better able than their patients to give effect to changes [italics the author's] in the extent of their concern." 1 544-45, Reder, "Medical Malpractice: An Economist's View," 1976 A.B.F. Journal 511.

8. Danzon, supra n.5 at 51.

9. Burghardt, "Medical Malpractice and the Supply of Physicians," in the Economics of Medical Malpractice, supra n.5 at 122.

10. H.E. Frech, III, at 282 in The Economics of Medical Malpractice, supra n.5.

11. Danzon, supra n.5 at 51.

12. Id. at 44.

13. "The potential for success of peer review is based on some further assumptions: that it is possible for peers to evaluate performance quality, that they have the will and the mechanism to bring malefactors to account, and that sanctions are available to punish misdeeds. All are required if self-regulation is to succeed in protecting the public. But there are, in fact, difficulties and obstacles in each of these areas, and in many respects the assumptions are unwarranted." Haug, "The Sociological Approach to Self-Regulation", 61, 64-65, in Regulating the Professions (R. Blair and S. Rubin, Eds 1980).

14. Pocincki, L.S., Dogger, S.J., Schwartz, B.P., "The Incidence of Iatrogenic Injuries," in *Department of Health Education and Welfare. Appendix: Report of the Secretary's Commission on Medical Malpractice* (DHEW Pub. No. (OS) 73-89, U.S. Gov't Printing Office, Washington D.C.) at 50, 51.

15. A study, jointly sponsored by the American College of Surgeons and the American Surgical Association, concluded that 796 of the 1696 deaths or complications arising out of 1,493 surgical operations examined were avoidable. C. Child, *The Critical Incident Study of Surgical Deaths and Complications* 1973-1975 (1975), discussed in "Study on Quality of Surgery is Unveiled," *Medical World News*, pp. 24-25 (January 26, 1976); *see* also Brody, J., "Incompetent Surgery Is Found Not Isolated," *New York Times*, January 27, 1976, at 1, col. 6. A study of the death rate in Los Angeles County during a doctors' work slowdown confirmed a drop in the death rate, linked to the sharply reduced amount of elective surgery performed during the slowdown. See "Death Rate in L.A. Fell in Slowdown by Doctors," *Washington Post*, October 20, 1978 at A6, col. 5.

16. Couch, N.P., et al., "The High Cost of Low-Frequency Events, " *New England Journal of Medicine* 304 (11): 634-37 (March 12, 1981).

17. Steel, K., et al., "Iatrogenic Illness on a General Medical Service at a University Hospital," *New England Journal of Medicine* 304 (11): 638-42 (March 12, 1981).

18. Couch, supra n.16 at 634.

19. Id. at 635.

20. Id. at 637. From a legal standpoint, according to the authors, "none appears to have involved negligence." The authors were concerned about their findings, and proposed that a legal safeguard was needed against malpractice suits for errors in judgment, i.e., "error simply related to flawed reasoning" as opposed to negligence. Malpractice suits only succeed, according to the authors, in driving into concealment the "forces that could help to reveal and control epidemiologic sources of error."

21. Steel, supra n.17 at 638.

22. Id. at 641.

23. Id. The authors gave no opinion as to negligence. They did call for better mechanisms ". . . to assess the hazards of hospitalization in an ongoing manner," id., for an intensified search for means to reduce the frequency and severity of iatrogenic events, and for a shared concern for deficiencies in medical review within the hospital.

24. If the harm to the patient is intentionally caused, the defendant's conduct will still be judged by the professional or ethical norms of practice of the profession. These cases are often dramatic, such as that of Dr. Nork, who performed countless surgical procedures which he knew to be unnecessary and which

he also knew he was incompetent to perform. Gonzales v. Nork, No. 228566 (Cal. Super. Ct., Sacramento County, Nov. 19, 1973), for excerpts, see S. Law, S. Polan, Pain and Profit: The Politics of Malpractice (1978) at 215-45.

25. See the T.J. Hooper, 60 F.2d 737 (2nd Cir. 1932); Marsh Wood Products Co. v. Babcock & Wilcox Co., 207 Wisc. 209, 240 N.W. 392 (1932).

26. W. Prosser, Law of Torts (4th Ed. 1971) § 32 at 165. See generally J. King, The Law of Medical Malpractice in a Nutshell (1977) at 136.

27. Prosser, id. at § 30.

28. King, "In Search of a Standard of Carefor the Medical Profession - The 'Accepted Practice' Formula," 28 Vanderbilt L. Rev. 1213, 1236 (1975).

29. Chumbler v. McClure, 505 F.2d 489, 492 (6th Cir. 1974) (Standard not determined "solely by a plebiscite.")

30. Downer v. Veilleux, 322 A.2d 82 (Me. 1974).

31. Hamilton v. Hardy, 37 Colo. App. 375, 549 P.2d 1099 (1976).

32. Toth v. Community Hospital, 22 N.Y. 2d 255, 262-63, 239 N.E. 2d 368, 372-73, 292 NYS 2d 440, 447 (physician must follow his best judgment, even if it requires precautions in addition to those customarily followed in community).

33. 519 P.2d 981 (Wash. 1974).

34. See Lundahl v. Rockford Memorial Hospital Association, 93 Ill. App. 2d 461, 465, 235 N.E. 2d 671, 674 (1968) ("what is usual or customary procedure might itself be negligence") - Favalora v. Aetna Casualty and Surety Company, 144 So. 2d 544 (La. Ct. App. 1962). See also Note, "An Evaluation of Charges in the Medical Standard of Care," 23 Vand. L. Rev. 729, 742 (1970).

35. Darling v. Charleston Community Mem. Hosp., 211 N.E. 2d 253 (Ill. 1965), cert, denied, 383 U.S. 946 (1966).

36. See Gorovity & MacIntyre, "Toward a Theory of Medical Fallibility," 1 J. Med. & Phil. 51 (1976).

37. Couch et al., supra n.16 at 636, Steel et al., supra n.17 at 639.

38. See Taub, "Wrongful Life - A Reply to Furrow," 10 Law, Medicine & Health Care 208, 210 (1982).

38a. The wrongful birth and wrongful life suits pose interesting questions involving medical technology. The dramatically improved ability of physicians to make diagnoses based upon such techniques as amniocentesis and ultrasound is at the root of such litigation and has spawned such new specialties as genetic counseling. See Fraser, "Introduction: The Development of Genetic Counseling," in Genetic Counseling: Facts, Values and Norms (A. Capron. et al., Eds 1979). Many of the cases illustrate zones of transition, with diagnostic error at the root of the litigation. In Curlender v. Bio-Science Labs, 165 Cal. Rptr. 477 (Cal. App. 1980), a child born with Tay-Sachs disease sued a physician and medical testing laboratories for negligently conducting certain genetic tests on the parents. The court recognized a need to encourage "careful genetic counseling and medical procedures," in light of the increase "of the medical knowledge and skill needed to avoid genetic disaster." Having considered the principles applicable to the suit by the infant plaintiff against the testing laboratory, the court concluded:

> We have no difficulty in ascertaining and finding the existence of a duty owed by medical laboratories engaged in genetic testing to parents and their as yet unborn children to use ordinary care in administration of available tests for the purpose of providing information concerning potential genetic defects in the unborn.

The second case, Schroeder v. Perkel, 432 A. 2d 834 (N.J. 1981) involved a suit brought by the parents of two children born with cystic fibrosis against the prediatricians who treated the first child but who failed to diagnose her condition in time for the parents to prevent or to abort the second pregnancy. Cystic fibrosis cannot be detected in a fetus through amniocentesis; however, the simple, safe and highly reliable "sweat" test may be performed on the child shortly after birth. A positive result indicates that the parents are carriers of the disease and that future children may also be afflicted with cystic fibrosis. Here, the treating physician never administered the sweat test, despite the symptoms shown by the first child. By the time the parents consulted a second specialist who performed the test and diagnosed the condition of the first child, Mrs. Schroeder was eight months pregnant with a second child. Curlender and Schroeder illustrate a trend toward judicial allowance of recovery for misdiagnosis of genetic defects. The increase in this type of litigation reflects advances in the understanding of genetic defects and improved diagnostic methods for predicting their occurrence. These cases illustrate the connection between improved medical knowledge and diagnostic procedures, and expanded tort liability. For a thorough earlier discussion of the problems, see Capron, "Tort Liability in Genetic Counseling," 79 Columbia Law Review 618 (1978); and "Father and Mother Know Best: Defining the Liability of Physicians for Inadequate Genetic Counseling," 87 Yale Law Journal 1488 (1978). For an extended debate on the merits of wrongful life litigation, see Furrow, "Diminished Lives and Malpractice - Courts Stalled in Transition, 10 Law, Medicine & Health Care 100 (1982), Taub, "Wrongful Life - A Reply to Furrow," 10 Law, Medicine & Health Care 208 (1982); Furrow, "Impaired Children and Tort Remedies: The Emergence of a Consensus," 11 Law, Medicine & Health Care 148 (1983).

39. For an interesting study on the effects of tort law on medical practice, see Comment, "Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff," 31 Stanford L. Rev. 165 (1978) (concluding that Tarasoff had produced substantial anxiety and had effected some changes in therapists' practice).

40. Watson, supra n.2.

41. Young, "Communications Linking Clinical Research and Clinical Practice" 177, Biomedical Innovation (E.B. Roberts, R. T. Levy, S. Finkelstein, J. Moskowitz, E. Sondik, Eds 1981).

42. Id. at 182.

43. Id. at 190.

44. See 210 Science 4467 (1980) (entire issue devoted to new medical technologies, providing an overview of recent developments in instrumentation.)

46. Id.

47. Pike v. Honsinger, 49 N.E. 760, 762 (N.Y. 1898)

48. In Peterson v. Hunt, 84 P.2d 999 (Wash. 1938), the defendant physician made a vaginal examination of the plaintiff and concluded that she was pregnant. However, it was later determined that she was not pregnant but had an ovarian cyst. At trial, the plaintiff sought to admit into evidence testimony showing that the rabbit test for pregnancy was 96 percent effective and was well recognized in the local area, but the evidence was excluded. On appeal, it was held to exclude that evidence since it was material

in deciding whether the defendant was negligent in failing to use the test earlier in the treatment.

49. Clark v. U.S., 402 F.2d 950, 953 (4th Cir. 1968) (blocked ureter, issue of intravenous pyelogram or cystopic examination as standard diagnostic procedure) quoting Smith v. Yobe, 194 A.2d 167, 173 (Pa. 1963).

50. Berman v. Allen, 404 A.2d 8 (N.J. 1979); Phillips v. U.S., 508 F. Supp. 544 (D.S.C. 1981).

50a. See Watson, "Liability for Failure to Acquire or Use Computers in Medicine" (unpublished paper on file with the author).

51. Capron, "Tort Liability in Genetic Counseling," 79 Col. L. Rev. 618, 671 (1978)

52. See Toth v. Comm. Hosp. at Glen Cove, 239 N.E.2d 368, 373 (N.Y. 1968). "There is no policy reason why a physician, who knows or believes there are unnecessary dangers in the community practice, should not be required to take whatever precautionary measures he deems appropriate." The institutional pressure, from hospital administrators, to adopt such technologies may also stem from fears of malpractice litigation and a perception that monitors provide a shield against liability.

53. B. Furrow, Malpractice in Psychotherapy 59 (1980).

54. See United States v. Simon, 425 F.2d 796, 805-06 (2d Cir. 1969) (the court held that professionals may be liable for acts a jury considers detrimental to the public interest whether or not professional organization guidelines have been adhered to. Compliance is persuasive, but not conclusive. The professionals in this case

were accountants who sought to use their adherence to generally accepted accounting principles as a complete defense). It may be that courts will accord more deference to medical professionals than to other professional groupings. However, cases like Helling suggest that where the professional practice has pernicious effects, courts will override the practice.

55. Price v. Neyland, 320 F.2d 674 (D.C. Cir. 1963). The rate of error in testing laboratories has been described as "massive." See Culliton, B., "Clinical Labs: Bills Aimed at Correcting "Massive" Problems," 192 Science 531 (1976).

56. Computed Tomographic Scanning (Institute of Medicine, National Academy of Science) (1977). The consensus on CT scanners is that they are now indispensable to radiologists; see Kolata, "Consensus on CT Scans," Science 214:1327 (1981) (this report on a conference sponsored by the National Institutes of Health also notes that CT scans may be overused in a variety of situations).

57. Davis, et al., "Some Limitations of Computed Tomography in the Diagnosis of Neurological Diseases," American Journal of Roentgenology 127:111 (July 1976) at 121.

58. In Price v. Neyland, 320 F.2d 674 (D.C. Cir. 1963) a mistake was made in the diagnosis and management of a child born of parents with an Rh factor blood incompatibility. Based upon incorrect laboratory tests, the physician misdiagnosed the jaundice which the infant showed, and he failed to give followup tests. The court quoted with approval medical testimony that "where laboratory tests are inconsistent with clinical findings, the laboratory tests should be re-run ... Id. at 677. Excessive reliance on computer-assisted diagnosis, in lieu of other traditional crosschecks, may ultimately lead to liability if the program malfunctions or is erroneously programmed for a certain disease or symptom. See Hall, Psychiatrists' Computer Use Stirs Debate," Wall St. Journ. p. 35, 39 (Dec. 6, 1983).

59. Fineberg, "Gastric Freezing - A Study of Diffusion of a Medical Innovation," in Medical Technology and the Health Care System 173 (National Academy of Sciences (1979).

60. See Federal Rule of Evidence 803(18). The problem is that either the expert has to rely on the periodical, or else the judge must take judicial notice under Role 201, and this requires a clearly reliable authority, a publication "recognized as a standard authority by the medical profession." See Generella v. Weinberger, 388 F. Supp. 1086 (E.D. Pa. 1974) (statements from a learned medical publication,

when independently used as evidence of truth therein asserted, are inadmissible as violative of hearsay rule); and Hemingway v. Ochsner Clinic, 608 F.2d 1040 (5th Cir. 1979) (medical malpractice suit, held that text written by two nurses was not shown to be reliable).

61. Finkelstein, Schectman, Sondik, and Gilbert, "Clinical Trials and Established Medical Practice: Two Examples" 213 in Biomedical Innovation (1981).

61a. Others have proposed national bodies to evaluate innovative procedures. See, e.g. Necheles, "Standards of Medical Care: How Does an Innovative Medical Procedure Become Accepted?", 10 Law, Medicine & Health Care 15 (1982). Unfortunately, no such national body presently exists.

62. Levine, "Clarifying the Concepts of Research Ethics," 21 Hastings Center Report at 22 (1979).

63. Commission: The Belmont Report pp. 3-4.

64. Standards of the Joint Commission on Accreditation of Hospitals (JCAH) as set forth in the accreditation manual, can be evidence of a standard of care. Darlington v. Charleston Comm. Mem. Hosp. 33 Ill. 2d 326, 211 N.E.2d 253, (1965) cert. denied 383 U.S. 946 (1966). Joint Commission on Accreditation Manual for Hospitals (1982 Ed.) Standard IV, pertaining to the Medical Staff, provides:

> "The Medical Staff shall provide mechanisms for the regular review, evaluation, and monitoring of medical staff practice and functions. Such mechanisms shall be designed to maintain high professional standards of care."
> JCAH Manual at p. 106

Hospitals will need to develop policies to deal with potentially unvalidated diagnostic and treatment approaches. See Cowan, "Hospital Responsibility for Innovative Therapy" (unpublished paper on file with the author).

65. P. Starr, The Social Transformation of American Medicine 425 (1982).

66. Id. at 415; See also Bovbjerg, "The Medical Malpractice Standard of Care: HMO's and Customary Practice," 1975 Duke L.J. 1375, 1386 n. 36; Binford, "Malpractice and the Prepaid Health Care Organization," 3 Whittier L. Rev. 337 (1981).

67. See, e.g., Foremski and Fohrman, "The Emergicenter: Has Its Time Arrived?" 11 Law, Medicine & Health Care 4 (1983).

68. See P. Starr, supra n. 65, particularly Chapter 5.

69. S. Reiser, Medicine and the Reign of Technology 156 (1981).

70. P. Starr, supra n. 65 at 428.

71. J. Gunther, The Malpractitioners (1978) at 7, citing results of a study conducted by the Insurance Services Office.

72. E. Freidson, Profession of Medicine: A Study of the Sociology of Applied Knowledge (1970) at 94.

73. See Havighurst, C.C., Tancredi, L.R., Medical Adversity Insurance: A No-Fault Approach to Medical Malpractice and Quality Assurance," Insurance

Law Journal 612:69-100 (February 1974), for a discussion of an attempt to couple financial incentives through insurance with risk disclosure. *See generally*, *Institute of Medicine, National Academy of Sciences*, *Beyond Malpractice: Compensation for Medical Injuries* (1978).

74. Payton and Powsner, "Regulation Through the Looking Glass: Hospitals Blue Cross, and Certificate-of Need," 79 *Mich. L. Rev*. 203, 273 (1980).

75. *Id*. at 274.

76. *Id*. at 275.

77. P. Starr, *supra* n. 65 at 428.

78. See generally S. Law and Polan, *supra* n. ___ at 97-119.

79. *Breeck v. Tucson General Hosp*., 500 P.2d 1153 (Ariz. App. 1972).

80. *Darling v. Charleston Community Mem. Hosp*., 211 N.E.2d 253 (Ill. 1965), *cert*. *denied*, 383 U.S. 946 (1966).

81. *See* 54 ALR 3d 258 for a list of cases.

82. See, B. Furrow, *Malpractice in Psychotherapy* (1980) at 82.

83. *Hoven v. Kelble*, 256 N.W.2d 379 (Wisc. 1977).

84. *Id*. at 391 (footnote omitted).

85. *Johnson v. Sears, Roebuck & Co*., 355 F. Supp. 1065 (E.D. Wisc. 1973).

86. *Id*. at 1066.

87. *Id*. at 1067.

88. *See* Judge Learned Hand's famous statement of the negligence calculus in *United States v. Caroll Towing Company*., 159 F.2d 169 (2nd Cir. 1947). "[T]here can be no ... general rule, when we consider the grounds for liability .... The ... duty ... to provide against resulting injuries is a function of three variables: (1) The probability of harm (2) the gravity of the resulting injury ...; (3) the burden of adequate precautions. Possibly it serves to bring this notion into relief to state it in algebraic terms: if the probability by called P; the injury, L; and the burden B; liability depends on whether B is less than L multiplied by P: i.e., whether B PL." (at 173).

89. *See* O'Connell, J., "Expanding No-Fault Beyond Auto Insurance: Some Proposals," *Virginia Law Review* 59(5): 749-829 (May 1973) at 790-94, for an analysis of the connection between culpability and predictability of risk.

90. Twiss, "The Problem of Moral Responsibility in Medicine," *Journal of Medicine and Philosophy* 2:330, 365 (1977); Baram, "Technology Assessment and Social Control," *Science* 180:465 (May 1973).

91. Schwartz, Komesar, "Doctors, Damages and Deterrance: An Economic View of Medical Malpractice," *New England Journal of Medicine* 293(22):1282 (1978). *See generally* G. Calabresi, *The Costs of Accidents: A Legal and Economic Analysis* (Yale University Press, New Haven) (1970).

92. P. Starr, *supra* n. 65 at 447.

93. *Id*.

94. The computer may pose liability problems for the hospital, ironically, at the same time that its capabilities allow for better quality control. The issue is the legal standard by which to measure computer-related errors. Are computer programs services, thereby subject to a negligence standard, or products, subject to strict liability? The issue has not yet been resolved by the courts, but one recent commentary concludes: "when hospitals, physicians, or programmers have considered the question of liability, they have tended to think in terms of negligence and malpractice. By creating, distributing, or even merely using computer programs, however, they may have moved toward the area of strict liability, formerly the domain of drug manufacturers, automobile manufacturers and other traditional industrial producers." Brannigan & Dayhoff, "Liability for Personal Injuries Caused by Defective Medical Computer Programs," 7 Am. J. Law & Med. 123, 144 (1981).

95. Fineberg, supra n. 59 at 191.

96. See, e.g., Grudner, "On the Readability of Surgical Consent Forms," New England Journal of Medicine 302(16): 900-902 (April 1980).

97. Doctrinal changes in tort law have altered the physician-patient relationship in the direction of fuller disclosure. See Novack, "Changes in Physicians' Attitudes Toward Telling the Cancer Patient," Journal of the Medical Association 241(9):897, 898 (March 1979), noting that in 1961, 12 percent of surveyed physicians generally told a patient about cancer diagnosis; by 1977, 98 percent reported a general policy of telling the patient.

Senator **Quayle**. Thank you very much.

Let me try to get a discussion going on the issue that is before this committee and the one on which your expertise will be much appreciated.

Obviously, because of the responsibility we have in administering medicaid and medicare, there is certainly a role for the Federal Government in the whole issue of health care costs. Although we've seen some improvement in the last 6 to 12 months for a number of reasons—one could cite the CPI reduction as being remarkable, being held down to 4 percent or below and we've now seen health care costs down around 6 percent, 6½ percent, 7 percent over the last 6 months, so you've seen some improvement—when you look at the projections in health care costs we are forced to ask what we're going to do about them. We've had a huge debate on whether to approach this in a systemic way or an incremental way. I personally favor the incremental way, although I'm not saying that that is the majority feeling, even of this committee, but it's certainly my feeling and I think that's the way that we're going to approach things for the next couple of years.

So if you take the health care cost problem and you sort of break it down—we started into the DRG prospective reimbursement as a way to begin to get at this problem. We have also examined HMO's and tried to accelerate their development. I've been a strong supporter of HMO's, and also the PPO's and the PPA's—trying to create the competitive environment out there where the market forces can take effect as a rational means to get a reduction in health care costs.

Another issue that has come up has been medical malpractice and we are looking at it as a place to take an incremental approach to partially solving, or to begin to partially solve, the health care financial crisis that is presently with us. I suppose that the definition of crisis is always in dispute, but if its not a crisis its something that is certainly being felt; if not in reality, certainly as a perception.

I would also say that the perception on the malpractice issue is that "defensive medicine," and I suppose that we ought to get into a definition of what "defensive medicine" truly means—that "defensive medicine" also contributes to increased health bills, an increased cost that in fact could be moderated or remedied by specific actions. AMA cites the statistic that "defensive medicine" costs $15 billion on an annual basis, although I think, Professor Danzon, you used a different figure. If you looked at the potential savings, that you could have a net effect or even come up with a $24 billion figure, I believe, in California——

Ms. **Danzon**. I said that that was an expectation of the costs of injuries due to medical negligence.

Senator **Quayle**. Injuries. Although I don't think you're going to wash out the $15 billion or the $24 billion, I don't want to confuse apples with oranges, but I think it's important that when you start to grapple with these numbers we determine whether we really have a $15 billion price tag because of the medical malpractice insurance, and if in fact we can do something to bring that down—I sort of detect from the four of you that you really do not believe that there is a so-called—I'm going to use the word crisis, although

I don't particularly like to—crisis in the area of medical malpractice and the whole malpractice system as we know it today.

What does intrigue me, and perhaps we can talk about this, and all of you sort of referred to it obliquely if not directly, are ways that we might be able to reform or at least change the system. Even if you don't want to go and say that there is a crisis, you're willing to try to do something with the problem. Professor Havighurst talked about the contract and that we ought to try to get more involved in private contracts. But you get into the difficult area of exculpatory clauses, and what can you really rule out? You can't rule out all negligence. Of course, you can try to define negligence, but I wonder if each of you would try to think along with me and to specify some direction that we might go in this area of medical malpractice reform. Professor Furrow mentioned that he didn't think that the Moore-Gephardt proposal was going to work, which was a rather direct, dramatic proposal. I think it does however go in the direction of trying to get the States to be responsive. My home State of Indiana has a program which places caps on the amount of an award and it's worked reasonably well in the State of Indiana.

How do we get the other States to do it? I wonder if you might just specify where you think we ought to be going. Maybe we'll start with you, Professor Havighurst, since you spoke to the mother of contracts. You might want to amplify on that particular proposal, and then I'll ask each of the other panelists to comment on that particular idea.

Mr. HAVIGHURST. I would endorse your observation that we perhaps do not have a crisis. I would say that we have a system that isn't working well and smoothly that needs attention, and the question of where one looks to find the fix is really what I'd be interested in exploring.

My remarks were really meant to say that we could look to nongovernmental sources for change, and it seems to me we have in place now negotiating patterns where organized health plans are marketing themselves to consumers, organized in employment groups, and there's a wonderful opportunity there, it seems to me, for people to rethink what they're getting under the present system and to decide that maybe it costs them more than it ought to, doesn't give them the financial protection that they really want because it requires that if you're going to get compensated, you go through a rather arduous and burdensome and unpleasant experience of litigating. At least in some cases.

And it might be that people could arrive at a different arrangement. I think we ought to open our minds to that set of possibilities.

As to the "defensive medicine" problem, the solutions there, I think, do not necessarily lie in changing tort law. They lie in changing the financing system; and it seems to me that the DRG reform under medicare is a marvelous response to the old problem of unlimited cost reimbursement which allowed providers of care to spend the public's money on anything they thought would be nice. That included spending money on things that might protect them against lawsuits in the future. That's "defensive medicine" as normally defined.

It seems to me that once you begin to impose some cost constraints on the system, that "defensive medicine" is likely to be among the first things to get squeezed out; and the best way to deal with the "defensive medicine" problem is to deal with the financing side. I think we're seeing that in the insurance reforms, in all the prepaid plans that have developed. I don't think one finds very much "defensive medicine" in HMO's, for example. It's when you have open-ended third-party payment, cost reimbursement that you get what I would call the wasteful "defensive medicine."

Senator QUAYLE. Do you think there is a lot of wasteful "defensive medicine?"

Mr. HAVIGHURST. I think that there is a lot of waste in the system due to the way we've been paying for it. We're gradually beginning to squeeze it out. The DRG reform, I think, is a major step in the direction of limiting the system's discretion to spend our money on things that aren't worth having.

Senator QUAYLE. You hear the comment time and time again that physicians prescribe tests, et cetera, just for the protection against malpractice suits. Is that exaggerated?

Mr. HAVIGHURST. It's really hard to pin down. I think doctors will tell you that because they think it's a wonderful way to discredit the law and the lawyers. In the old days, 10 years ago, the AMA was not willing to admit to "defensive medicine" at all. In those days the idea was that no doctor would ever do anything that wasn't totally in the patient's interest, and the AMA's official position was that there wasn't any such thing. Lately that's changed, but I think it is essentially an attempt to discredit the legal system.

But there is waste in the system. I think it comes not primarily from the tort system, though that surely does influence some behavior; but I don't think the answer is to change the tort system. It's to limit the ability of providers to spend the money on things that are primarily for their own protection, not for the patient. That means putting caps on what the system will pay for, as the DRG system does.

Senator QUAYLE. I see. Thank you.

Mr. Furrow? I'm sorry—Mr. Rosoff?

Mr. ROSOFF. You read me as saying before, Senator, that I didn't think there was a crisis, and what I was really reacting to was the use of the word crisis which I see as a stampede word. It stampedes you to too-fast action.

I think there really is a serious problem, and as I was trying to point out, a serious problem that existed 10 years ago still exists in that the patient-plaintiff cannot get a resolution of their claim, particularly small claims, promptly and adequately. I think that's something that still needs to be addressed as much as it did a decade ago.

I suggested that some kind of screening mechanism or arbitration mechanism might be very helpful, particularly in the smaller claims. There was a statistic that Richard Carlson, in a symposium, quoted—again, about 10 years ago, and I've not seen an updated statistic but I would assume it's still relatively correct—it said that of every dollar spent for malpractice insurance premiums by health care providers, only about 16 cents of that dollar ultimately went to pay out compensation to patients. the other roughly 84 cents was spent on the system—on lawyers, on defense strategy. And that's an inefficiency. I'm not sure——

Senator **Quayle**. I think that figure is overstated—or understated, if you will. I tried to run it down once and you couldn't find where it came from. If it had any validity at any time, it was during the period when insurance rates were going up astronomically in anticipation of future claims; and to compare the current premiums with current payouts wasn't necessarily the way to measure the net that was actually returned eventually to patients.

I think Patricia has some numbers on that point that might be enlightening.

Mr. **Havighurst**. Are you more comfortable with 38 percent?

Senator **Quayle**. What figure would be acceptable?

Mr. **Rosoff**. In the Duke University study of "defensive medicine" in the early 1970's in which Professor Havighurst participated, the write-up suggests 38 percent going to the injured patient, which is a lot better than I was saying, of 16 or 14 percent.

Senator **Quayle**. But it is still a costly system and the point is still a fair one, but it's not quite as bad as that other number.

Mr. **Rosoff**. I used the most dramatic figure; we all fall into that from time to time, I suppose.

At any rate, I do think that there is a need for some very careful looking at the various screening systems that the States have adopted since 1975. Roughly 22 States impose some kind of arbitration or mediation or screening panel system. Some of the States claim very great success: Wisconsin, Hawaii, Massachusetts are very pleased with their systems. Some of the systems have been disastrous in some of the other States.

But the systems vary tremendously in the way they are structured and the way they are operated and the way they are supported by both the medical and the legal professions. And I think there's a real need to go back and look at the States' experiences and do a kind of desk-practices scan and try to synthesize. I think these systems have the potential for really streamlining the system and achieving efficiencies, both in terms of speed and in terms of costs.

You were talking about a Federal role. I don't see any other player on the horizon now to do this kind of synthesis of individual State experiences but the Federal Government. The time of massive soft money in foundations supporting this kind of research is not here. Of course, the Federal Government is not in a position to put lots of money into research either, but it seems to me a uniquely Federal role to look at States' experimentation and try to figure out what is good and what is not so good, and to disseminate that information. Then it may be possible to design some kind of carrot-and-stick legislation, or carrot legislation——

Senator **Quayle**. What would make a good pretrial screening system? What are the ingredients?

Mr. **Rosoff**. Well, one major point about pretrial screening systems is that the jury is inefficient, and judges—there's lots of good things about juries, I'm a believer in that system—but in technical, complex areas like medicine, you've got to educate lay people about some very sophisticated concepts. Even judges are not sophisticated there. So that a panel that would include, as most of them do, a lawyer, a physician, or a health care provider, and a lay person or a judge would go towards a more efficient way of handling this.

Many of these screening systems were put together with very little clout. They couldn't force a case to come up rapidly. They couldn't subpoena witnesses. They couldn't gather the evidence that was needed. So they're really a very weak sister as a first hurdle before going on to a full-blown trial. The notion of the systems was that you could get a fast resolution through a rather sophisticated panel mechanism and not have to go to a trial; and as it's worked out, that's just been a first step and trials are much more common after that.

There are also State constitutional limitations. You can't do away with a jury trial. You can impede someone's progress toward a jury trial somewhat, but not too much or you have violated their constitutional rights. But I think that some of the States have creatively worked with that and managed to have effective screening systems that do not step on a person's constitutional rights, and I think there is a way of doing that.

Senator QUAYLE. Professor Danzon?

Ms. DANZON. Thank you.

In response to your question of what should be done, I fully agree with Professor Havighurst on the merits of allowing contracting-out of the system to private initiative. But I don't think that this should be viewed as an alternative to tort reform. The two are not mutually exclusive. The tort system will always provide a baseline against which private contracts will react, so private contracts can modify the basic framework but the tort system will still provide the basic framework. And therefore I think it's important that that framework be set in an efficient manner. I think that tort reform probably is optimally left to the States, but the Federal Government might perform a useful role in establishing model legislation that would indicate the types of legislation that might be considered constitutional; because one of the major problems with the tort reforms enacted in the States has been that there has been a tendency to reject them as unconstitutional. Some of the caps have been thrown out on that grounds.

What form might such a model bill take? Again, I think that the most important reform would be to replace the current system of individualized awards for pain and suffering and economic loss with a simple schedule which would pay economic loss only. I think that such a schedule, based on the age and severity of the injury, is superior to a single cap, which has been adopted in several States, because a single cap hits hardest at the young, severely injured plaintiff that has the highest economic loss. So I think a schedule is superior to a simple cap.

On the question of what fraction of the malpractice insurance premium dollar gets to the patient, I think that 30 to 40 cents on the dollar is a more reasonable estimate. And although it's true that 60 cents on the dollar is costly as a cost of operating a compensation system, I don't think we should view it that way. The point is that the tort system is not primarily a compensation system. It's primarily a system of quality control, and if you view the 60 cents on the dollar that's spent litigating over fault as an alternative to spending money on the costly regulatory bureaucracy, it's probably quite a cost-effective system of regulation. So I think it's very misleading to compare the costs of compensating through the tort system with the costs of compensating through first party insurance, where the only function is compensation.

Senator QUAYLE. Mr. Furrow?

Mr. FURROW. I'll echo the sentiments of Professor Havighurst with regard to defensive medicine. I continue to be skeptical of the evidence for defensive medicine and what I would suggest is that you watch the effect of the DRG legislation over the next 2 years. And I would project that the level of medicine which is related to testing will drop off substantially. Economic incentives have changed. Reimbursement policy has got to be the focal point for evaluating medical practices which are characterized as defensive. My guess is, that's the pressure point rather than the tort system with regard to this kind of cost.

I'll make a second point with regard to this. There are economic forces which are operating in the system which I think will have an effect on the level of malpractice litigation, regardless of what we say here today. For example, there's a recent article—it's in the last issue of the New England Journal of Medicine—comparing HMO's with fee-for-service in a controlled setting. It's a result of a several-year study. I think it has interesting implications if you pursue it, because the conclusion of the study is that physicians practicing in a prepaid group practice, in this case an HMO, ordered—or, had a much lower level of hospitalization for members of that plan compared to fee-for-service physicians. The implications of that are the following: Since 80 percent of all malpractice claims arise in the hospital setting, as HMO's proliferate the level of hospitalization drops; the level of malpractice litigation, malpractice claims, also begins to drop, independent of reforms in the system.

So I think as economic pressures push toward a prepaid or group practice, malpractice is going to tag along and the frequency of litigation, my guess is, will drop. And that's independent of Federal reforms or State reforms.

A third point is that I would echo Professor Rosoff's focus on dispute resolution mechanisms. I teach in Michigan; Michigan has an elective arbitration system whereby, when you enter the hospital, you can elect arbitration rather than common law litigation. A study has just come out in the last 2 months as to the efficacy of that system; and while it is not conclusive, it suggests that there are some cost savings as a result of arbitration, in that you get your final award a little more quickly even though you get a little less money. It may turn out to be a very successful option that patients can elect.

Michigan also has a mediation system which is optional for all litigation, not just malpractice, and it seems to be very effective in reducing the level of cases which go to trial. It really speeds the settlement process substantially.

So I think the States, as laboratories, are worth studying and pulling the data together to see what the future might hold.

Senator QUAYLE. Let me ask one other question. We talk about trying to get contracts into the system rather than perhaps relying on the courts.

What obstacles stand in the way of that, and what might we do on an incremental basis to encourage more reliance on contracts rather than the normal tort process, the contracts that Professor Havighurst points out and that have been echoed by the other members of the panel? What obstacles do you see and what can we do to remove them? I think that in trying to synthesize a direction—at least I discern from this panel that might be a proper way to go—I need each of your comment on that. The screening process is another additional thing, but I'm looking at something that we might get our hands on to do something if we really want to try to encourage reform.

What impediments are there, and what can we do about them specifically?

Mr. HAVIGHURST. The great impediment, I gather, is that lawyers are conservative in their approach to problems of this kind and would be inclined to tell their clients that the contracts won't be enforced. And what one has to do is try to overcome that conservatism on the part of the lawyers, and that may mean persuading the courts that they should not, themselves, be conservative.

Senator QUAYLE. How will we go about that?

Mr. HAVIGHURST. Jeffrey O'Connell tells me that he's spoken to lawyer groups about the use of private contracts to change the tort rules, and that he frequently encounters real hostility from the audience, an audience of lawyers. They respond negatively to the idea that private contracts could be written to solve the problem that the parties perceive and mutually agree to try to deal with. It's very curious that lawyers themselves don't seem to believe in the institution of private contracts anymore.

Senator QUAYLE. Be careful. My wife is a lawyer. So am I. [Laughter.]

Mr. HAVIGHURST. That's all right.

Well, if the fault lies anywhere, it lies in the law schools which seem to treat contracts as an occasion to litigate, not something to be enforced, and I worry about that.

Senator QUAYLE. Yes, I think it's fair to say that there is a reluctance in the law profession to do this. Whatever the reason may be, it's there; it's real, it's permanent.

Is there something that we can do in the area—I doubt if it's in the area of tort law. Is there something that we can do specifically to provide incentive or encouragement to utilize these private contracts?

Mr. HAVIGHURST. One could imagine legislation that would order courts to enforce private contracts. The problem there is that the legislature would—well, in other words, you would say that such contracts will be deemed enforceable unless—but that could become quite regulatory in terms of dictating the negotiating circumstances. But perhaps in HMO legislation, one could say that the provision of a subscriber contract, a provision in a subscriber contract may include a provision that limits damage awards and negligence litigation, substitutes no-fault compensation for the negligence cause of action. There are some other things. One could imagine legislative approaches. I'm not sure that's in order; I would certainly think, though, that we should begin talking about this alternative as we explore other alternatives, and not act as if the only solution is one that legislatures should come up with.

I think if we talk about it enough that people will start thinking and pushing their lawyers into going back and trying again, tell them not to be so conservative, that some Senate committee said that private contracts were a fruitful line of exploration and, therefore, maybe we ought to take that seriously. I think that there is some room for leadership for opening up these new possibilities, observing that they exist, and encouraging the private sector to take some initiative on its own. I'm not sure that we need legislation at this point; I think there are other things we could do. I think this conference I'm thinking of next year is a way of getting people all thinking about these possibilities at once, and I hope that that will start things in that direction.

Senator QUAYLE. Mr. Rosoff, do you have——

Mr. ROSOFF. I yield my rights to Professor Danzon.

Senator QUAYLE. OK, Professor Danzon?

Ms. DANZON. I would just like to add that I think that we will see more use of private contracting emerging as there is a growth of preferred provider organizations. I think that one reason we haven't seen more of it previously is that for the individual patient there's very little incentive to contract out of the tort system when he's paying for his health care on a fee-for-service basis, because he'll get very little of the savings.

When the contracting out is made part of the entire insurance package, as it might be under a preferred provider organization, then the savings in malpractice costs would be figured into a reduction in the cost of health insurance; and that would be a real incentive to patients to opt for that sort of thing.

So I think as we see more preferred provider organizations growing up, and more contracting for specific insurance packages that restrict patients to particular groups of providers, we will see more private contracting for restricted tort rights.

Mr. HAVIGHURST. May I say one thing, just to follow that up?

It seems to me that it works the other way, too, that the providers—in organizing a preferred provider organization, if you go to see a doctor and say, "Doctor, I'm here to ask you to cut your price," he might throw you out. But if you say, "But in addition, I can give you some substantial relief from malpractice suits," he might invite you to sit down and talk about it a little more. I think that the incentive might work in terms of encouraging more organized health plans to develop as people start experimenting with this particular carrot to induce participation.

Senator QUAYLE. Professor Rosoff?

Mr. ROSOFF. You asked what impediments there were to moving toward this contract, and I guess a fairly obvious one is the constitutional limitation. If the patient-plaintiff has a right to a jury trial, the waiver of that right—say, before admission to a hospital—is something that has to be handled very carefully. It has to be fully informed and voluntary on the patient's part.

There has been an experiment with California hospitals—I believe it was in the late 1960's—where patients were given an option as they entered the hospital—I guess this would only be in an elective case, where they had time to consider it—to waive their right to a jury trial and agree to arbitrate if there were any disputes that arose out of that care. And then, to avoid the constitutional problem, patients were also given up to 90 days after discharge from the hospital to opt out of their prior agreement. So that tended to get around the constitutional limitation. The question that arises, how do you motivate patients to accept that? What's the trade-off for them? I think Professor Danzon is right; if you tie it into the insurance mechanism you might find some incentive there. But one of the things that was reported from the California experience was that patients were fairly ready to accept this kind of arbitration agreement. And the way it was presented to them was, the provider said, "We just want you to know that if something bad happens and you feel that it's because you were improperly treated in our facility, that we are not going to insist on interposing the entire legal system of the State of California between you and your right for recovery." So that may be viewed, and the California experience tends to suggest that it was so viewed, it may be viewed as an opportunity for a patient.

I think there's a real problem in getting a rapid resolution of any claim. Tied into a system might be something where the patient was promised that there would be a resolution within a particular period of time. That's very difficult to pull off, but the Moore-Gephardt bill speaks towards that same sort of thing, a shortening of the time period. If people knew, going in for health care, that if they agreed to arbitrate, that there would be some benefit coming to them if they did have a claim—that is, in terms of a more rational and more expeditious resolution— they might opt for it. You don't have a constitutional problem if people waive their right to a jury in a voluntary and informed manner.

Senator QUAYLE. Professor Furrow?

Mr. FURROW. With regard to the impediments to mechanisms such as arbitration, if Michigan is again an example I can use, the Michigan supreme court recently upheld the elective arbitration option as constitutional in Michigan. So, on a State-by-State basis, this hurdle is being jumped.

It strikes me that one option that one could consider for medicare-medicaid utilization is collective arbitration, for example. I hesitate to suggest mandatory arbitration, but it could be offered to patients who are medicare-qualified; and with the kind of options that Professor Rosoff suggests, a relatively-quick payoff in the event of a claim could be a very attractive alternative, could save a great deal of time, and avoid the courts altogether.

Senator QUAYLE. Well, I thank you all very much for your testimony and look forward to working with you and your comments on this and other things.

The next panel is John Rolig, Gerald Engleleiter, Donald Steffes, and L. Savannah Lichtman.

The first witness will be John Rolig from St. Paul Co., St. Paul, MN.

STATEMENT OF JOHN E. ROLIG, UNDERWRITING OFFICER, MEDICAL SERVICES DIVISION, ST. PAUL FIRE & MARINE INSURANCE CO.

Mr. Rolig. Senator Quayle, I am speaking on behalf of our company including Gerry Engleleiter, who is also noted on the list of witnesses.

This panel is basically one of insurance companies, and we do have some different structures as companies, and so I thought I'd briefly outline what we are.

We are a large property and casualty insurer group, a multiline company, and we do business through independent insurance agents in all the States and the District of Columbia. We are what is known as a commercial insurer in our trade, and that distinguishes us somewhat from the other members of this panel.

Medical malpractice is a very large item for our company. We have approximately a 14.6-percent market share and that translates into about $278 million in medical malpractice premiums in 1983.

In summarizing my statement I think that one aspect that I'd like to emphasize is our current loss analysis picture. Many articles that have been written suggest that rates are going up 25 to 30 percent annually in the foreseeable future, if you will. Rates are made by two components, primarily: frequency, which has been alluded to by the prior panel, and severity. Frequency is the number of claims per an insured basic unit—per hospital bed, per physician, per outpatient visit, that type of thing. In 1974, using our own data, we had 2.6 claims per 100 base class physicians. In 1983, that number was 5.3, so it was nearly double over that 10-year period.

For hospitals, the number was 1.5 per 100 insured, occupied beds, and that number also doubled by 1983 to 3.1.

Now, when you couple that with the other factor of rates, which is severity—and severity is loss and allocated loss expense per reported claim, how much we pay out per claim—in 1974, per physician, we paid out $9,063. In 1983 that was $19,718. So if you couple that severity with that frequency, both of which have doubled over 10 years, since they are to some extent multiplicative, you can see a very high degree of loss over that 10-year period. Likewise with hospitals; in fact, the hospital severity has gone up more than that with physicians.

Actuaries combine these thinqs into what is called pure premium, and that basically is the average loss per our insured basic unit. Since 1974 to 1983 on a physician basis, that's gone up 338 percent; and on a hospital basis, it's gone up 436 percent in that 10-year period.

Over a 10-year period of time, I suppose if you look at the cost of living and the CPI, and so forth, that may be quite a relative item. What concerns insurance companies, I think, is that we normally look at the most current period of time because that gives us the closest look at where we are right now. And for our most recent history, the last 5 years has been much worse.

I see that I have very little time left, but I think that an aspect of that that this committee probably is aware of, and which should be pointed out, is what does a physician pay or what does a hospital pay? That varies by specialty and by geographic area. Our average physician—and averages are figured in lots of different ways—but our average physician for $100,000 of coverage pays $3,500 over the country. The average hospital pays 435 beds for $300,000 of coverage. Both of these increase if their limits of coverage are higher; but they also vary by area. In Arkansas, for instance, a hospital pays $219 per bed. In Florida, they pay $1,011 per bed; it's a great variation. Doctors also vary, not only by area, but also by specialty so that a general practitioner doing no surgery in Arkansas pays $586, but a neurosurgeon in Dade and Broward County of Florida pays $35,663. The variation is very high based on area and based on specialty. And that's for low limits of coverage. Most of our physicians purchase high limits of coverage, which would about double those numbers.

Why the disparity? I'll just make a quick listing as we see it. I think the cost of living is one thing. If one considers Arkansas versus Florida, the cost of living is higher. I think that translates into, what does it take to compensate an injured worker or a patient who has died? The worth of that individual, if you will, based on that cost of living is more significant than in some other geographic areas.

Another is the practice of medicine itself. We believe that the practice of medicine has gone from a cottage industry to a corporate one. We have high-tech kinds of centers; and in those high-tech centers, primarily in the urban areas, there are more significant kinds of treatment and probably less personable types of treatment, and that also leads to malpractice problems in the urban areas versus the rural areas.

Then, of course, as has been cited significantly by the previous panel, the State legal systems vary significantly. In your State you mentioned the caps, and the patient compensating funds certainly provide a capping area for physicians and hospitals. Some States are what I would call wide open, and that makes a big difference.

So primarily, I guess, if we're looking at solutions, I think that recognizing that malpractice does occur, one of the big things for insurers and providers is loss prevention. How do you prevent those losses? A number of our companies, as well as insurers, have coordinated in establishing loss prevention programs which have been meant to reduce the incidence of loss, and I think they have been successful to some extent. They need to be continued.

Also, I think the frictional costs of the system itself need to be addressed, need to be looked at, probably on a State-by-State basis since the system primarily operates on a State-by-State basis. We have long advocated binding arbitration, but as I indicate in my statement, binding arbitration is not really something that has taken off. Primarily, arbitration that has been put into place has served as a second discovery system and, therefore, adds costs, rather than reduces. Sliding scale contingent fees have been advocated both by the bar and the medical profession, as well as by insurance companies. We think that that is appropriate. And the idea of structured settlements, which we think is very helpful towards reducing the frictional costs of this system.

With that I'll close and let some of the other members speak.

[The prepared statement of Mr. Rolig follows:]

STATEMENT OF
ST. PAUL FIRE AND MARINE INSURANCE COMPANY

Presented by
John E. Rolig
Underwriting Officer
Medical Services Division

I. INTRODUCTION

Members of the Committee:

The members of this panel represent various kinds of insurance companies. The St. Paul Fire and Marine Insurance Company is a 131 year old, stockholder-owned, multi-line insurance company. We sell all types of commercial and personal insurance through independent insurance agents in 50 states and the District of Columbia.

St. Paul has been selling medical malpractice liability insurance since the 1930's. We are the largest provider of medical malpractice insurance in the country with a 14.6% market share as of year end 1983. Our agents sell this insurance to physicians and surgeons, hospitals, nursing homes and other health care providers such as nurses, dentists, emergency medical technicians, blood banks, and perhaps 200 other designated professionals and professional facilities across the country. In the medical malpractice marketplace we are referred to as "commercial carrier".

Our medical malpractice liability premium volume as of 1983 was $278 million. This represents about 15% of our company's total written premium. When combined with ancillary insurance coverage also written through our Medical Services Division for medical-oriented insureds, our total medical related written premium as of year end 1983 was $395 million or about 25% of our total business. Needless to say, insurance sold to the medical community is important to us.

II. HISTORY

In order to shed some light on the current situation, a brief history of the medical malpractice market might be helpful.

For the first thirty years, from the time we began writing this business until the late 1960's, medical liability insurance was a relatively stable line of insurance. In the early 1970's, it became apparent that this stability was vanishing. The frequency and severity of reported claims began to increase sharply, a consequence of society's increased expectations from the medical profession, economic and social inflation and changes in legal doctrines. We and our competitors responded by increasing insurance rates, oftentimes in double digit increments.

The insurance market during this time consisted almost entirely of commercial insurance carriers like The St. Paul. As the frequency and severity of claims continued to escalate, the risk of loss continued to grow and fewer of the commercial insurance carriers were willing to risk their capital by writing medical malpractice insurance. As a result, the market constricted in the mid-1970's, and some health care providers had difficulty buying professional liability insurance at any price.

Because of this constriction, new organizations were formed to fill the void. Temporary, state-created Joint Underwriting Associations relieved some of the pressure.

Also, many of the hospital associations and physician associations formed their own companies. These companies, generally patterned in the mutual insurance company mode, were established primarily as single-line companies delivering medical malpractice insurance directly to the insured, and limiting their writings, in most instances, to a given state. These two phenomena, JUA's and society or association-owned or sponsored companies helped relieve the 1975 availability of insurance "crisis".

What has transpired in the succeeding ten years? While The St. Paul has actively continued and expanded its medical malpractice market, most other commercial carriers have withdrawn, or at least restricted their writings. On the other hand, the society or association-owned or sponsored carriers have grown to a position where they now make up about 60% of the marketplace. And so, insurance is available and the "crisis" of the mid-1970's has passed.

III. CURRENT LOSS ANALYSIS

But many articles have been written about a new "crisis". The central issue, however, is not the availability of insurance, rather, it is the cost or affordability. Insurance rates continue to rise. Annual rate increases of 25-30% are foreseen and health care providers are paying a greater percentage of their income for malpractice insurance.

Frequency and severity are the components of loss and thus are the measures from which rates are made. Frequency is the number of claims per insured basic unit -- for instance, per insured physician, per occupied bed, per outpatient visit, etc. Over the last ten years, countrywide frequency, based on our own statistics, has risen nearly every year and shows a constant upward movement over the years. For instance, in 1974, we had 2.6 claims per 100 insured base class physicians; in 1983 5.3. In 1974, we had 1.5 claims per 100 insured occupied hospital beds; in 1983 3.1. Frequency for these two classes of health care providers has more than doubled in the last ten years.

The other component of loss does not appear to have performed much better. Severity is loss and allocated loss expense per reported claim. Severity likewise has more than doubled for physicians since 1974. In 1974 we paid out $9,063 on the average; in 1983 $19,718. For hospitals, the situation has grown even worse. In 1974 we paid out $4,707; in 1983 $12,785 or nearly triple the amount.

These two factors are combined actuarially into a third factor - pure premium. Pure premium is the average loss per insured basic unit. For the most part, this is the amount of money we must collect to cover loss payments and attorney's fees. For base class physicians, pure premium has risen from $241 in 1974 to $1,056 in 1983, or 338%.

For hospitals, it has risen from $73 to $391, or 436%. In a very simple summary, there are more claims than in 1974 and those claims cost more today. As insurers, however, it is more important to look at a shorter term view. And that view today is somewhat disconcerting.

For physicians, the largest increases have occurred in the most recent five years. From 1974 to 1978, pure premium went from $241 to $357, a $116 or 48% jump. However from 1978 to 1979, it jumped $123 to $470 and from 1979 to 1980 it jumped $98 to $569. And the increases have been even greater in the last three years - $134 in 1981, $204 in 1982 and $150 in 1983 - or a 199% increase over that five year period. Likewise, hospital pure premium has deteriorated more rapidly in recent years, having gone from $72 per insured, occupied bed to $106 for the five year period 1974 to 1978 and from $106 to $391 in the last five years.

It is this more recent loss history that has driven the significant rate increases, and it is this trend that causes the forecasts of continued significant rate increases in the foreseeable future.

IV. PREMIUMS

Currently the average physician pays us about $3500 for $100,000 of coverage with an aggregate loss limit of $300,000 on a mature claims-made policy. Depending on a physician's specialty, insurance may cost more. For instance, a neurosurgeon (our highest rated specialty) pays 10.5 times as much as a general practitioner doing no surgery, our lowest rated physician. Needless to say, other specialists are somewhere in between. For $300,000/$900,000 coverage, the average hospital pays $435 per bed. Higher limits of coverage naturally cost more.

While these are "average" countrywide rates, they vary from state to state, and sometimes for different territories within a single state, based upon our experience.

For example, our current hospital rates range from $212 per bed in South Carolina, to $219 per bed in Arkansas, and $1011 in Florida. In ten states our per bed rates are in the $300-$399 range, 11 states are in the $400-$499 range and 9 states between $500-$599.

For physicians, our highest rate is in Florida's Dade and Broward counties . There, the physician in general practice doing no surgery pays a mature claims-made rate for $100,000/$300,000 of coverage of $3501. But, elsewhere in Florida, that physician would pay $2333. In Arkansas, that same physician would pay $586. The neurosurgeon would be charged $35,663 in Dade and Broward counties, $23,758 in the remainder of the state and $5403 in Arkansas. However, most of our insured physicians purchase $1,000,000/$1,000,000 coverage. For that coverage, the premium would be roughly double the figures I have just cited.

V. REASONS FOR DIFFERENCE

Why is there such a dispairity? Our rates reflect our experience within a particular geographic area. This experience is accumulated over a period of years. Where such experience is not fully credible (i.e. limited), experience of similar states within a region and our national experience also are considered in rate making. By doing this, we try to avoid serious swings due to random or unusual events. Nonetheless, these random or unusual events do effect our experience and profitability.

The causes of differences between geographic areas are more difficult to pinpoint. Certainly, the cost of living is a factor. It costs more to care for an injured party, wages of a disabled plaintiff are greater and certainly lost income of a deceased worker is more in Miami than it is in Little Rock. Certainly, these factors cause loss severity greater in one area than in the other.

An intangible loss factor is what we call social inflation. By this we mean the apparent inflated feeling that one is entitled to certain results and that society through the jury will see that such results, if not achieved, will be compensated. This affects both frequency and severity.

Even the manner in which medicine is practiced appears to be a factor. As medicine moves from a cottage industry to a corporate one, the personal relationships which once deterred patients from sueing their doctors has diminished. Further, with the explosive advances in medical knowledge and technology, patient expectations have, in some instances, become unrealistic. This "high-tech" and corporate practice of medicine is more likely to be present in the large urban, tertiary care centers. Accordingly, the more urbanized areas tend to reflect both greater frequency and severity.

State legal systems differ as well. Some states have capped losses, some states have reduced statutes of limitations, some states have legislated a scale of attorney's fees and some states have modified the burden of proof. These developments, and many, many others, contribute to the constantly changing legal climate.

Why is Miami more litigious and more expensive than Little Rock? We believe the previously cited factors, and perhaps others, define the unique social fabric of each particular area and account for many of the differences.

VI. SOLUTIONS

Prerequisite to searching for solutions to the growing malpractice dilemma, all concerned parties must first accept the fact that malpractice does occur. In the 1976 California Insurance Feasibility Study conducted on behalf of the California Medical Association and the California Hospital Association by a team led by Don Harper Mills, it was determined that patients admitted to hospitals experience adverse incidents 4.65% of the time. In approximately 17% of these events, legally recognized faulty practice occurred.

Hence, our first priority must be to find ways to reduce the number of malpractice incidents. Toward that end, we have pioneered incident reporting and occurrence screening in hospitals. We and other insurers support strong peer review, quality assurance committees, and stronger licensing and credentialling processes. We have just introduced an ambulatory care risk management model putting occurrence screening into the clinic setting. We have developed a self-audit checklist to assist the practicing physician in reducing risk.

Further, we have commissioned learned studies on infectious disease and on brain damaged infants to determine if possible problem areas could be averted. The results of these studies, other studies and actual case problems are reviewed in our publication, Malpractice Digest to inform health care providers of problematic areas. All of this, and more, is done to try to reduce the incidence of malpractice.

Second, we support efforts to reduce the frictional costs within the system. We have advocated binding arbitration. However, this concept has been modified in many jurisdictions so that it is no longer arbitration, no longer binding and is little more than additional costly discovery. We have further supported plaintiff attorney sliding contingent fee scales. These provide for the delivery of more of the awarded dollar to the injured party, thus reducing the cost to the system, while at the same time providing the lawyer with adequate compensation. We also strongly support the use of structured settlements for serious claims. This helps provide the severely injured party with guaranteed maintenance over a lifetime and minimizes the risk that the recovery may be mismanaged or squandered, and that the injured party may become a ward of the state. It also can be less costly to the insurer, and thus reduces costs to the system.

Finally, in the area of tort reform we have long advocated certain modifications to the tort system. These seemed to us to be appropriate and equitable means to reduce the frequency and severity of claims. Legislation was needed to control or more clearly define a variety of legal elements of the malpractice problem.

Accordingly, at more than 37 hearings in 1975 we advocated that the health care provider should not be presumed negligent without proof...he/she shouldn't be required to testify against himself to establish standards of acceptable practice in his specialty...expert medical witnesses for the plaintiff should be licensed in the defendent's specialty and practice either in the state of the defendant or an adjacent state..."informed consent" should be judged as a medical question on the basis of the acceptable standard of practice in the local community...some reasonable limit is needed on how many years after the incident a patient can sue...medical examining boards need adequate authority, funds and staff to properly police the ranks of the medical profession.

These tort reforms in the areas of burden of proof, statute of limitations, ad damnum clause, collateral source and informed consent have been enacted in many states. We continue to advocate them. Perhaps other suggestions should be reviewed on an individual state basis. We stand ready to assist.

Senator QUAYLE. Thank you very much. Second is Donald Steffes, President, Phico Insurance Group.

STATEMENT OF DONALD G. STEFFES, PRESIDENT, THE PHICO INSURANCE GROUP

Mr. STEFFES. Senator Quayle, we appreciate the opportunity to speak before you and your committee.

After 30 years in this highly volatile line of business, allow me to start with the following premise which I believe the committee should bear in mind throughout their deliberations. That is, first, in this United States of America we are privileged to have the highest quality of medical care available through the highest degree of professionalism.

Second, we have the latest in scientific equipment and technical advances available to us.

Third, medical malpractice is the result of human medical error, caused by physicians, surgeons, and other health care providers in human error. Not only medical malpractice, but other areas, cannot be legislated against.

Fourth, the majority of the unanticipated results or less than the perfect outcome is not necessarily negligence or malpractice. And bear in mind that medicine is not a perfect science.

With that, allow me to make a few remarks about our company as a supplement to the text I gave to you. We are one of the newly formed companies that resulted from the crisis in the mid-1970's. These newly-formed companies now—I'm with the Pennsylvania Hospital Insurance Co., Pennsylvania Casualty Co.—these new companies came into being when the commercial carriers all but abandoned the market. They are presently writing 53 percent of the malpractice market nationwide, and this is increasing greatly every year. We write over 400 health care providers in 21 States and over 8,000 doctors. We are the major carrier in Pennsylvania, which is among the top five largest producing malpractice States in the country, which is something we're trying to get rid of. We also are the endorsed carrier for the Hospital Association of Indiana. We write actively here in Washington, DC for physicians. We are the endorsed carrier for the Medical Society of Delaware, and so on.

But let me give you a positive approach as to what the private sector can do and is doing to correct this problem that not necessarily should be addressed by Federal legislation. Why are we successful when the others failed? We are successful because we are committed to a firm, mandatory program of risk management and quality assurance. And now we're talking to you about somebody that's in the trenches; we're out there in the real world. We aren't just sitting back, analyzing statistics; we're there developing the statistics for you to analyze and decide what you want to do with them. We get them. Presently in Pennsylvania, we get 145 new malpractice cases a month, of which 105 are already in litigation. We could carry this through, so we know whereof we speak. In 8 years we've had over 8,000 malpractice cases presented to us, just in the State of Pennsylvania.

The answer is a strong commitment to education, to risk management, and to quality assurance. We have four full-time doctors on staff that will get out to the hospital and the physician community and speak to the doctors. There is a great void at the medical schools in teaching the doctors as to what goes on out in the real world as to patient care, how to treat the patient, how to communicate with the patient. So we fortunately have recently been able to get on the Hershey Medical Center curriculum for a 4-hour program to teach the doctors that, "Look, when you get out there you'd better learn that you've got to be a reasonable businessman and communicate with the people or they're going to put you out of business through malpractice." That is one area.

Last year we gave over 700 inservice programs reaching over 6,000 health care providers on what is going on and how to prevent malpractice.

We have a very aggressive claims management program. We know what is happening; 36 percent of the indemnity dollar we pay out to our own defense attorneys in defending cases. And this is an area in which our defense attorneys need as much policing as the plaintiff's attorney. Remember, the plaintiff's attorney doesn't generate malpractice; you've got to be injured, you've got to have a complaint before you go into the plaintiff's attorneys to see what's going on.

Arbitration is a good area. We had 1,400 cases pending in Pennsylvania through the Mandatory Arbitration Panel when that was declared constitutional; those cases are now all in common pleas court. We're working in Philadelphia with the seventh judicate panel provision, which is a long time coming off the ground; we have all kinds of contentions by the plaintiff's bar, as well as the defense bar, "Don't change the system." These are active areas that we're working on.

Where are we today? Back in the crisis of 1976, the combined loss/loss expense ratio was 112 percent for malpractice. Now it is 154 percent, so something positive has to be done. The investment income that is generated from the premium dollar will no longer offset the underwriting loss that is taking place in the medical malpractice area. Our statistics are similar to St. Paul's; in our position now—and these are our own statistics—we receive 20 claims per 100 positions in active practice. We receive two claims per 100 occupied beds. These are well supported statistical data. Our claims projections are increasing at the rate of about 15 percent per year; our hospital losses are increasing at the rate of 10 percent or 11 percent per year. The catastrophic loss fund in Pennsylvania alone, which is similar to the patients' compensation fund in Indiana, paid out $54 million last year on only 183 claims involving 183 health care providers, and it is anticipated that will exceed $60 million this year.

So we do have the numbers, but we are not discouraged. Our own average costs per claim, including all claims—both nonlitigated, as well as litigated—went from $12,000 in 1976 to about $18,500 now in 1983. So the progression is there, and these are things that we have to address positively by education, risk management, and quality assurance. We are very concerned about the new areas of litigation, in the antitrust area and in the area of credentialling.

This is a new ball game; the plaintiff's bars are conducting seminars on how to bring litigation in this area, and it's extremely expensive. In some areas there's an overabundance of—this is going to impact. The DRG's that you mentioned this morning is of great concern to us. We are getting enough claims now, sending patients home either through a misdiagnosis or sending them home early; now, when the DRG cuts them off at 6 days and they send them home whether they're healed or not, it will take us 3 or 4 years before we are able to put a price tag on what this new system, if at all, is going to impact on the health care system.

Positive action requires assistance and cooperation with the State legislative bodies. We know that that's not the answer; as you know, that was the answer in 1976, 1977 and 1978, and now 50 percent of that litigation has been declared unconstitutional. It didn't work. So we can't be solely dependent on that; we have to take the positive approach by dealing day-to-day, hand-in-hand with the health care providers.

We recommend limitations on the discovery time, which you've heard; an effective arbitration system to speed up the process; expansion of the collateral source rule, and the modification of the contingency fees. You've heard numbers batted about this morning, and it is true; I think it's about a 36, 37 percent that gets back into the patient's pocket. That is a great social injustice because there are people out there that are maimed by the inadvertent maloccurrence that should be compensated and compensated on a timely basis so you can get to them early enough to rehabilitate the patient, not before they are declared to be a permanently-impaired individual that really has no cause for life.

So in conclusion, we are working with the hospital associations and the physicians' groups in all the States that we are in that medical professional liability is a contributing factor in health care cost inflation. This must receive the attention of the hospitals and the doctors and all health care providers. We must act to minimize the incidence of medical malpractice by doctors and hospitals through more aggressive identification of incompetent behavior, and that's where legislation is needed, although I can tell you, don't hang your hat on the fact that they're all incompetent doctors; they're not. That is less than 1 or 2 percent of the total practicing doctors. Ten percent of the claims account for 90 percent of the dollar loss, and I think you'll see statistics all over the country to support that.

We need action by the general assemblies of the respective States to streamline the adjudication and administration of medical malpractice claims in order to maximize the proportion of malpractice awards that actually are paid to injured victims.

Third, we need measures by the general assembly which will assure that malpractice awards are justified by the economic losses suffered by the injured parties. We are firm believers in structured settlement and these notorious $10, $12, $15 million awards serve no purpose, really, to accomplish the end or to really, truly compensate the patient. Most of those or for maintenance, et cetera, in a very disastrous situation.

So we thank you for this opportunity and we'll be glad to respond to any questions that you may have.

[The prepared statement of Mr. Steffes follows:]

TESTIMONY PRESENTED TO

THE

UNITED STATES SENATE
COMMITTEE ON LABOR AND HUMAN RESOURCES

BY

DONALD G. STEFFES, PRESIDENT
THE PHICO GROUP

ON

JULY 10, 1984

Senators, on behalf of The PHICO Group, I would like to express my appreciation for this opportunity to address you on medical malpractice.

The PHICO Group consists currently of three companies--the parent, Pennsylvania Hospital Insurance Company--and its two subsidiaries, Pennsylvania Casualty Company and Pennsylvania Insurance Management Company. The parent company was formed in 1976 to provide medical malpractice coverage to hospitals in Pennsylvania. Its creation was prompted by the announced withdrawal of the primary commercial carrier for that coverage in 1975. No other commercial carriers were willing to take over that book of business for approximately 140 hospitals, and numerous options were explored by the trade association representing hospitals, The Hospital Association of Pennsylvania. To further compound the issue, state legislation passed in November, 1975 mandated professional liability coverage and specific limits for Pennsylvania's health care providers. Numerous options were explored by the Association, including the development of an off-shore captive.

The Association finally determined to form its own company, owned by the hospitals in the state and a per-bed assessment for hospitals was made to capitalize the company. Credit must be given to the Pennsylvania Insurance Department for recognizing the crisis atmosphere existing at the time and was instrumental in processing our application and charter expeditiously.

It was determined at the outset the company would be run as an insurance company, owned by the hospitals in Pennsylvania but with the management and board of the company to be separate and distinct from the Hospital Association. We have a seven-member board of directors chaired by the President of the Hospital Association of Pennsylvania and which includes one hospital administrator. Beyond that, the board was selected from among the trustees of Pennsylvania hospitals and were chosen for their business expertise. Our board includes bankers, lawyers, investment and business representatives.

In 1978, the hospitals in Pennsylvania expressed interest and concern over the shrinking availability of Workers Compensation coverage. In response, Pennsylvania Casualty Company was formed by us as a subsidiary company to handle workers compensation and other additional lines of business.

In 1979, we embarked on writing independent physician malpractice coverage through Pennsylvania Casualty Company, based on the interest expressed by graduating resident physicians previously covered by us under a hospital policy.

In 1980 at the request of a major producer in the District of Columbia to provide coverage for physicians in that jurisdiction, we initiated our first venture outside of Pennsylvania.

In 1983, Pennsylvania Insurance Management Company was formed as another subsidiary to provide a variety of insurance services to self-insured facilities. These include services such as claims and risk management, and publications such as the nationally-recognized, Hospital Risk Control.

At the present time we are in the process of developing a group health insurance, alternative delivery product for hospitals and other employers in Pennsylvania.

Today, we are the 11th largest carrier for medical malpractice in the country and are licensed to provide coverage to health care providers in 19 states and the District of Columbia. We have been endorsed as the preferred malpractice carrier by the Hospital Association of Pennsylvania, Indiana Hospital Association and Medical Society of Delaware for their members.

We are providing coverage to over 400 health care facilities which include acute care and specialty hospitals, nursing homes, clinics, and hospice programs; and over 8,000 physicians. We now have regional offices in Indianapolis and Denver, as well as an office in Richmond, Virginia.

In a number of jurisdictions we have established Retrospective Premium Return or Dividend plans which return to policyholders any monies not used for losses, as well as a share of any investment income. Due to the long "tail" of malpractice claims, returns are calculated three or four years after the policy year, depending on the jurisdiction. Under this plan, we have returned over $ 34 million to hospitals in Pennsylvania and Indiana, and physicians in the

District of Columbia over the past five years. These represent calculations on policy years 1976 thru 1980, and in one instance 1981.

The PHICO Group has traditionally offered and prefers to write claims-made coverage for medical malpractice. We feel very strongly that occurrence coverage does not permit accurate determination of premium rates because of the nature of malpractice claims. As you know, many claims are not discovered or reported until years after an incident occurs and the cost of handling and defending these claims rises with each passing year. Under claims-made coverage we are able to adjust rates more flexibly and reduce the impact of severe rate hikes over time.

We believe we have been successful for a number of reasons. These include strong corporate commitments to:

1) Reduce The Incidence of Malpractice Claims. From our inception, we carried the belief that aggressive risk management can reduce exposures for malpractice claims and introduced such a program in our insured hospitals. Last year for example, our insured hospitals averaged 18 percent in premium credits for good risk management efforts which resulted in the average hospital paying 95 percent of manual premium (experience modifications increased 13 percent). Our risk management program includes extensive annual surveys of our hospitals and quarterly consultation conferences. Our staff works with the hospital to assist them in establishing their risk management program. We are in the process of developing a risk management program for physicians applicable to their office practice.

2) Educate And Communicate With Policyholders On The Causes Of Malpractice. Last year, we presented nearly 700 in-service education programs in our insured facilities. These programs were directed to nurses, physicians, medical record technicians and other segments of hospital personnel.

Since the physician controls many of the elements which give rise to malpractice claims, we target many efforts to addressing medical staff meetings, physician practice groups, and house staff physicians. We make a concerted effort to educate medical students, interns and residents in our insured teaching facilities because we believe sensitivity to risk management and medical malpractice is critical in their developing years. In too many instances, these issues are neglected in medical school curricula.

We encourage contact from policyholders and do get questions from many.

We communicate through various media, at least monthly in print through educational bulletins, and through use of filmed presentations as well.

3) Retention Of Experienced Professionals. We retain an experienced staff drawn primarily from the health care and insurance industries. Those from insurance are primarily medical malpractice specialists with extensive years in the industry. Our health care representatives in risk management include former hospital administrators and quality assurance professionals.

We have four full-time physicians on staff who possess many years of clinical, teaching, and administrative experience. All told, we have in excess of 200 employees, nearly half of which are in the risk management, claims and medical areas. Their expertise and experience have enabled us to communicate more effectively and establish credibility with insureds.

4) Aggressive Claims Management. We retain control of claims throughout the entire process. We will vigorously defend non-meritorious claims regardless of the cost of defense. That philosophy has been tested by plaintiff attorneys and our reputation for this is now recognized.

We select counsel experienced in medical malpractice to defend our claims in each state.

We have established a legal unit of in-house attorneys within our claims department to work with outside counsel for complex claims to expedite, direct and monitor those cases.

Our physicians also conduct a medical review of all large claims to provide their final analysis and determination as a further guide for appropriate action.

We are concerned over the cost of claims, both indemnity and expense, and have so advised our defense attorneys. We are exploring the development of a flat-fee payment system, as opposed to fee-for-service, with some of our defense counsel as a pilot project to implement this year. We are actively working with a Judicate System in eastern Pennsylvania, which is a fee-for-service private arbitration system which uses the services of attorneys and judges as triers of fact. Indeed, we will use arbitration systems wherever possible, when agreed to by all parties.

5) Planned Growth Strategy. Unlike many of the "bedpan mutuals" formed during the medical malpractice crisis of the 70's, we made the decision early to execute a strategy of planned growth for the companies. Recognizing the cyclical nature of the insurance industry we knew our "captive" market of Pennsylvania hospitals could easily evaporate in later years. The future stability of the company had to be ensured with a broader spread of risk. Thus, the decision to write additional lines in additional states was reached.

We have carefully examined the states we have entered to accomplish this planned growth strategy. We have selected those states whose litigious climate, claims experience and regulatory environment offer to us the opportunity to 1) commit to a long term market availability, 2) and provide a spread of risk which would benefit our existing policyholders. We have turned down offers of writings in states which do not enable us to meet these objectives.

6) Sound Actuarial Rate Setting. Due to the volatility of medical malpractice rates, in the earliest years of our development if we erred, it was on the side of caution in our ratemaking. Rates at that time were developed primarily by outside actuarial counsel, after analyzing country wide data as well as data from the former hospital carrier. We now have in-house actuarial capability, as well as in-house experience and data from which to determine our own rate, which is set with consideration also given to country wide data.

From inception, we determined a sound actuarial rate was critical to the future stability of the companies. We have been licensed but do not market our product actively in areas where we feel competing rates are inadequate. We will not "buy the business", and we have rejected what we feel are overtly bad risks. We do not surcharge individual physicians for claims. We do reserve the right to cancel or reject bad risks. We are concerned less with the provider that incurs one or two claims, even if high, than with the provider who has a consistent string of claims which could indicate bad practice patterns.

The problems faced by the medical malpractice insurance industry today are quite different from the crises of the mid-70's which involved both price and availability. The availability question has been resolved in most states with the formation of physician and hospital-owned captive insurance mechanisms, and in many cases increased competition from commercial carriers. The concern today is the price of coverage and how this price impacts on health care costs generally.

We have not calculated nor can we calculate the cost of defensive medicine. Some health economists and the American Medical Association have published estimates on these costs as high as $15.1 billion. I would, however, like to focus on medical malpractice costs from one carrier's viewpoint. Up to this point we have preserved our fiscal stability. Our pure loss ratio at year-end 1983 was 58.2 for both physicians and hospitals. This is contrasted with an industry-wide pure loss ratio for medical malpractice of 105.2. Loss ratios reflect the costs associated with claims for each dollar of premium collected. Not included in these figures are the costs necessary to maintain normal insurance expenses such as taxes, operating expenses, commissions and payroll. PHICO's combined loss ratio, which includes all operating expenses, was 117.8 for year-end 1983. Combining the industry's 1983 pure loss ratio with 1982 operating expenses for medical malpractice (1983 expense figures not yet published) results in an anticipated combined ratio of approximately 151.7.

The 61.6 expense ratio for PHICO in 1983 includes incurred loss adjustment expenses of 36.9. Considering premium and other related taxes,and commissions paid to brokers, our Company has exceptional control over its operating expenses at 24.7.

We are seeing a trend indicating a future rise of 15 percent per year for physician losses, primarily due to the increased frequency of claims which we are receiving now at a rate of 20 claims per 100 physicians. Since first writing independent physicians five years ago, we have increased premium rates 66 percent.

For our first six years of operation, we had seen stability in the hospital experience, and in fact filed for rate reductions. However, in the last several years,this experience has deteriorated and now we are projecting our hospital claims will increase 11% over the next year, primarily due to the increased severity of claims. Our frequency has remained relatively constant , at slightly over two per 100 beds.

The attached exhibit portrays the rise in both physician and hospital claims and suits for 1982 and 1983 and indications are that 1984 figures will show additional rises.

In Pennsylvania, where the majority of our insureds are written, a Catastrophe Loss Fund exists to provide coverage over the primary layer. This state-administered Fund is supported by a surcharge on primary insurance premiums and is paid by the health care providers. This year's surcharge is 52 percent of the basic premium. In 1983, the Fund paid out in excess of $54 million on behalf of 183 health care providers. Most cases involved multiple defendants. In the area of medical malpractice, plaintiffs are sometimes indiscriminate in whom they sue. Time and money spent in sorting out the liability in cases naming multiple defendants results in additional claims costs.

Even though a majority of press accounts of medical malpractice claims tend to focus on those over $100,000, and even more so on those over $1 million, the preponderance of claims are those which come to us under $100,000. Our average hospital claim in Pennsylvania has risen from $12,100 in 1979 to $18,900 in 1983, a 56 percent increase. This is approximately one-half of the countrywide average as reported by the Insurance Services Office.

We estimate that slightly over one-half of the claims filed against our insureds have merit.

Nationally, malpractice awards are increasing at an average rate of 20 percent per year. For the malpractice industry as a whole, the underwriting loss after dividends totalled $2.3 billion for the five year period 1979 through 1983.

The profit has gone out of malpractice, even with the higher premiums of recent years. The malpractice line is reaching the point where investment income can no longer compensate for the underwriting losses.

The rate "crisis" today is really not so different from that of the seventies. It's only the major players that are different. Over 53 percent of the medical malpractice coverage is now being written by the newly-formed companies of the seventies. Some of these facilities are in financial trouble and the majority of the Joint Underwriting Associations formed from that era are a financial disaster. We are also seeing the reinsurance market and capacity beginning to constrict for medical malpractice in the face of increasing losses.

We are alarmed too at the new areas of litigation confronting health care providers and predict a significant increase in cases involving anti-trust and credentialing issues.

Another source of concern is the impact of federal, state and local initiatives to contain health care costs. Will we see reductions in quality of care, which could result in more malpractice suits, commensurate with reductions in reimbursement? Only time will tell.

In summary, the primary contributing factor to malpractice costs is malpractice claims. Solutions must be developed which 1) reduce the incidence of malpractice claims, and 2) reduce the cost of malpractice claims.

Risk management and quality assurance initiatives must be enhanced. As a specialist carrier for health care providers we will continue to explore and develop more effective programs. For example, we are now developing a statewide, statistically reliable, computerized system which couples risk management controls to specific high risk areas for the individual health care facility.

Improved credentialing and licensure procedures must be developed and enforced to ensure that incompetent providers are discovered and removed from active practice. State licensing boards, professional societies, and institutional peer review committees must become more aggressive and effective in these efforts.

The cost of malpractice claims can be reduced by legislative initiatives aimed at tort reform, which are fair and equitable to all parties.

As a Company, we support effective limitations on discovery time and the establishment of effective arbitration programs with the purpose of speeding up the processing of malpractice claims. Incorporated within this system should be provisions for appeals on the record, rather than de novo.

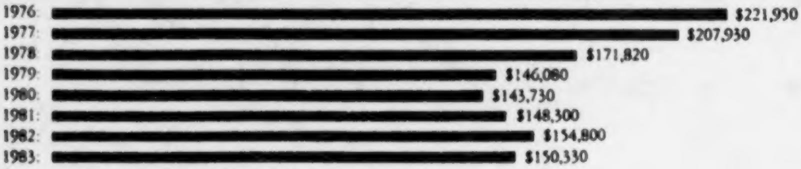
We seek expansion of collateral source rules to include all collateral sources of money.

We seek some modification of the contingency fee schedule to ensure that injured plaintiffs receive a fair share of awards.

We also seek a legislative framework that permits the effective administration of structured settlements.

Generally, we seek equity for both plaintiffs and defendants through equal treatment by the courts of their rights to protection from unfair advantage to either. Only through such equality can we hope to see both the protection of fundamental constitutional rights and the maintenance of some realistic economic correlation between injury and damages awarded.

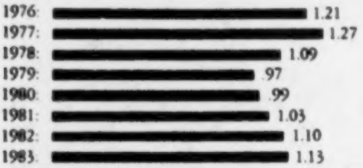
Average Annual Liability Insurance Premium
PHICO-Insured Facilities*



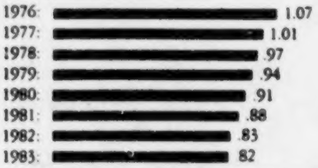
* Based on a representative sample of Pennsylvania hospitals insured since 1976.

Average Survey and Experience Modification Factors

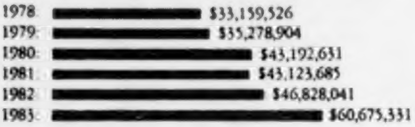
Average Experience Mod



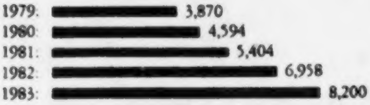
Average Survey Mod



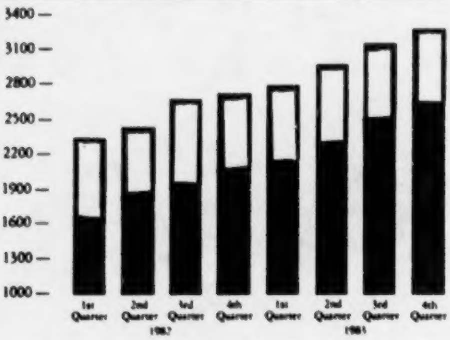
Consolidated Gross Written Premium
PHICO/PCC



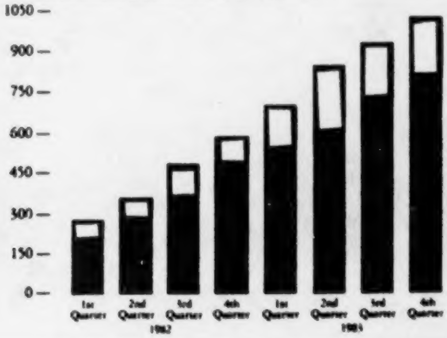
Physician Professional Liability Insureds



Hospital Claims & Suits
Pending Counts—(Quarterly) 1982 to 1983
(dark area shows number of suits/light area shows claims not in suit)



Physician Claims & Suits
Pending Counts—(Quarterly) 1982 to 1983
(dark area shows number of suits/light area shows claims not in suit)



Source: Phico Group 1983 Annual Report

Senator QUAYLE. Thank you very much.

Our next panel member is Ms. Savannah Lichtman, vice president and general counsel for Norcal Mutual Insurance Co.

STATEMENT OF L. SAVANNAH LICHTMAN, VICE PRESIDENT AND GENERAL COUNSEL, NORCAL MUTUAL INSURANCE CO.

Ms. LICHTMAN. Thank you, Senator Quayle.

NORCAL is a physician-owned and operated insurance carrier, and we're very pleased that you've recognized and asked to receive input from the physician carriers. There are 36 of us in 26 States and the District of Columbia; altogether, we write over one-half of the physicians in these States.

NORCAL is a single-line carrier. We have 6,000 policyholders and $40 million of annual premium. All of the physician-owned carriers are represented by a trade association called the Physician Insurers Association of America. So we do compile statistics and act as a group.

Like its counterparts, NORCAL was born in the crisis of availability in the mid-1970's. We saw a situation where the commercial carriers made a mass exodus from the market, and physicians realized that their medical malpractice insurance was tantamount to a license to practice medicine. They realized that without insurance they felt insecure. Many of them curtailed their practices. There were strikes. Others took early retirement, all to the detriment of people needing medical treatment. The result was a desire among many physicians to control their destinies, which translated into a desire to control their insurance companies.

That's the way we differ most significantly from the commercial carriers. We have a board of directors comprised entirely of policyholders, nine physicians who are extremely active in every aspect of the company's operations, particularly claims and underwriting. We have extremely active policyholders as well. We have regular communication from them; they ask provocative questions. We've had 70-percent participation in our loss prevention programs, and great participation in attempts to get reform and in participation as amicus curiae in various constitutional issues that have gone before our Supreme Court.

NORCAL is very well operated; we've received an "A" rating from A. M. Best, and I think that our operations can be considered a model of the rest. You would see throughout the Nation very, very active participation of doctors and policyholders in the operations of the company. But no matter how well operated we are, we do foresee a crisis of affordability in the future.

The judiciary, especially in California, is constantly expanding novel causes of action against physicians, and also against insurance carriers. We've seen a proliferation of bad faith litigation that has been accepted by the judiciary when insurance carriers have not promptly compensated victims, even though the reason for doing that has been a reasonable belief that the physician can be defended. In California, third parties can bring direct causes of action for bad faith against insurance carriers.

Our own medical malpractice legislation has been plagued by constitutional attacks, the collateral source rule, the cap on pain and suffering; the kinds of things that have been discussed here today have never really gotten the opportunity to be effectuated in California because of the constitutional attacks. We believe that we need ameliorative legislation from the Federal Government.

Therefore, although it does have problems, we were encouraged to see something like H.R. 5400; and, as I say, we do support many of the concepts underlying it—the prompt compensation for deserving patients, the collateral source offsets, periodic payments, elimination of compensation for pain and suffering.

In California we do have PPO's that have been approved by the legislature, but we have not seen a commensurate change in the standard of care adopted by the judiciary. The judiciary has defensive medicine at the heart of the standard of care, and as long as that is at odds with matters of cost containment, there's every reason to believe that physicians will be left holding the proverbial bag of liability. In the event that a physician permits cost containment to be a factor in his or her treatments and a patient is injured, I have a feeling that our judiciary would not have a very warm reception if cost containment is at the heart of defense.

So we would recommend that the Federal Government make some statement about the standard of care being permitted to include matters of cost containment.

I thank you very much for the opportunity to address this group. I do hope you will call on us again if any additional information would be helpful.

Thank you.

[The prepared statement of Ms. Lichtman follows:]

STATEMENT OF NORCAL MUTUAL INSURANCE COMPANY PREPARED FOR THE SENATE COMMITTEE ON LABOR & HUMAN RESOURCES REGARDING MEDICAL MALPRACTICE CLIMATE

Management and Operations

NORCAL Mutual Insurance Company (NORCAL) is a physician-owned and operated insurance company. NORCAL provides professional liability insurance and office premises coverage to approximately five-thousand seven-hundred and seventy-six (5,776) individual physicians, five-hundred and fifty-four (554) entities and twenty-nine (29) clinics, laboratories and blood banks.

NORCAL was established in a crisis environment in the mid-1970s in order to ameliorate a medical malpractice insurance availability and affordability problem. Like many other physicians throughout the country, California physicians had faced exorbitant premium increases and a mass exodus from the market by the commercial carriers which had previously offered medical malpractice insurance.

As a result, there was strong support for the creation of a medical malpractice insurance carrier owned, operated and controlled by physicians with their best interests determining the goals of the Company. Physicians perceived the need for an ongoing source of insurance protection, which is tantamount to a license to practice medicine in the current litigious environment existing throughout the nation.

Thus, NORCAL's goals are very straightforward: It is the intention of the Company, effectuated through the guidance of the Board of Directors, to maintain a long term and financially sound source of professional liability insurance coverage for their colleagues at the lowest possible premium consistent with prudent business practices. The Board, as well as the Company's management and consultants, continually search for different and creative ways to make NORCAL's insurance program responsive to its policyholders and the overall professional liability problem.

Further to the accomplishment of these goals, NORCAL's directors participate closely in every aspect of the Company's operations. It is in this way that the physician-owned medical professional liabilty carriers (of which NORCAL is an excellent representative) differ from the commercial carriers.

NORCAL's Board of Directors is comprised of nine (9) practicing physicians of varying specialties who are insured with NORCAL. They practice and reside in different sections of the State. Thus, they represent NORCAL's policyholder base. Seven (7) county medical society executives, representing NORCAL's sponsoring societies, act as consultants to the Board, attending all Board and most Committee meetings. They provide input on current trends and problems and assist in the policy making function of the Board.

NORCAL's Board, along with two (2) additional physician-committee members, are intensely and pervasively involved in every aspect of the Company's operations and this interest and participation is credited as a primary reason for NORCAL's enjoyment of favorable operating results.

NORCAL's underwriting is accomplished by a staff of insurance professionals. However, seven (7) directors and a physician-committee member have final approval of all underwriting decisions. Further to that, the physician-comprised Underwriting Committee meets approximately every six (6) weeks and more frequently, if necessary, to review files and recommendations made by the underwriting staff. NORCAL's Board and Management, as well as its policyholders, maintain that direct physician involvement is intrinsic to NORCAL's success in the volatile business of providing medical malpractice insurance coverage.

All of the nine (9) directors and the two (2) physician-committee members comprise NORCAL's Claims Management Committee. That Committee exhaustively reviews all claims with a settlement or judgment potential exceeding one-hundred thousand dollars ($100,000); complicated or unique cases; and, those which are defensible, but difficult or risky from a litigation perspective. This availability of expertise at a basic level in conjunction with excellent orchestration and management by a claims department comprised of experienced insurance professionals has resulted in an eighty-five percent (85%) success rate of all cases litigated.

NORCAL's Marketing Committee is comprised of three (3) directors and one (1) physician-committee member. They understand the changing practice requirements of their colleagues and make sure that NORCAL's insurance package keeps pace. For example, NORCAL has special programs for residents, and young, retiring, disabled and part-time physicians, all in an effort to be responsive to the varying needs of its diverse policyholder base.

Three (3) of the directors and one (1) physician-committee member comprise NORCAL's Investment Committee, thus insuring that the goals of the doctors who brought NORCAL into being continue to be reflected in the Company's investment portfolio. NORCAL has a full-time, in-house investment advisor who keeps the directors and management closely apprised of the fluctuations and vagaries of the investment market. The Company's investment philosophy is to obtain maximum return without taking undue security risks, thus generating sufficient cash flow to pay dividends and continue regular contributions to surplus.

NORCAL's Audit Committee is comprised of four (4) physician-directors who closely monitor both the internal and external audit functions.

Perhaps one of NORCAL's most salient and effective accomplishments, in which the Board takes particular pride, is NORCAL's Loss Prevention Department. Recognizing moral and social obligations to patients, NORCAL has been a pioneer in developing programs to enhance patient safety, and as a corollary, prevent losses to physicians. This year, NORCAL instituted a program of day-long loss prevention seminars during which physicians are educated on a variety of medical-legal topics and advised, through lecture, video presentation and question and answer on the application of the laws pertinent to their practices and the essential underpinnings of such things as communications; standard of care; accurate, informative record keeping; and new developments in case law that affect the day-to-day practices of each physician. It is significant that approximately seventy percent (70%) of NORCAL's policyholders have taken or enrolled in the seminar. NORCAL publishes a bulletin containing interesting, timely claims prevention information, the Claims Rx.

NORCAL is a "not for profit" company; when NORCAL's underwriting results are better than anticipated, profits are returned to the policyholders through dividends. To date, NORCAL's dividends total twenty-two million (22,000,000) paid or declared to be paid to policyholders. This is an extension of the corporate goal of maintaining a stable premium level and adequate loss reserves; it is safer to issue dividends after the fact than risking the unknown by decreasing premiums on the basis of prediction - which has not been known for its reliability in the medical malpractice insurance market.

Moreover, by the end of 1984, all subordinated loans made to the Company by physician policyholders in order to capitalize NORCAL in 1975 will have been returned.

NORCAL has managed to keep its premium level stable; since its inception in 1975, the pure premium rate has increased by only approximately twenty percent (20%). Unfortunately, frequency and especially severity continue to escalate. Continuing expansion by the judiciary of novel causes of action exacerbate a potentially volatile situation. According to recent statistics, California's medical malpractice losses are up one-hundred and six percent (106%). A recent tabulation issued by the Insurance Information Institute indicates that California's trial courts awarded $31.8 million to medical malpractice plaintiffs in 1983 compared to $15.4 million in 1982. The average award was $649,210 as compared to $257,222 in 1982. Obviously, this will affect premiums. Two of California's medical malpractice insurance programs have already been affected by these negative factors in that they reported 1983 underwriting losses; one such carrier has an accumulated eight (8) year loss of $18.3 million.

It has been predicted that a crisis of affordability is in the offing. The implications for overall health care costs are far reaching.

To date, NORCAL has managed to stay ahead of the impact of increased frequency and severity. The Company's diligence was recently acknowledged in a tangible way: A.M. Best Company awarded NORCAL an "A" rating and described the Company as "unusually successful... for medical malpractice coverages."

Tort Reform Proposal

NORCAL is active in the legislative and judicial arenas, working both independently and in conjunction with the California Medical Association, assisting in its lobbying efforts by providing technical information as needed. A legislative alert system has been established through which policyholders are informed about legislation pertinent to their practices pending before the California Legislature; communication from the policyholders to their respective representatives on key issues is encouraged. NORCAL also participates in the judicial process by filing amicus curiae briefs on matters relevant to the practice of medicine.

NORCAL's primary involvement in the judicial arena has been as an amicus curiae on the constitutionality of California's medical malpractice legislation, the Medical Injury Compensation Reform Act

(AB 1XX). AB 1XX has been under constant constitutional attack since its enactment and a variety of cases challenging the constitutionality of each provision of AB 1XX have been pending before the California Supreme Court for several years. This is an unfortunate turn of events as many observers contend that the provisions of AB 1XX have had a significant impact on maintaining stability in the medical malpractice climate in California, but would be much more effective if the question of constitutionality were answered favorably.

Because NORCAL maintains that certain provisions of AB 1XX have had a favorable impact on the Company's experience, it might be useful for this Committee to consider the primary features of AB 1XX.

AB 1XX provides that in any action for injury or damages against a health care provider, the Superior Court shall, at the request of either party, enter a judgment ordering that future damages in excess of fifty-thousand dollars ($50,000) be payable periodically rather than by lump sum. From NORCAL's inception in November, 1975, to date, NORCAL has saved approximately two million dollars ($2,000,000) by use of structured settlements to satisfy claims and awards. This has had a most favorable impact upon premiums.

This is particularly significant in that the savings to NORCAL and, ultimately to its policyholders, have not impaired the financial compensation obtained by the plaintiffs with whom structured settlements were effectuated. In fact, good authority supports the position that most recipients of structured settlements are better off than their counterparts who receive lump sum awards. It has been shown that most recipients of lump sum payments are ill-equipped to handle the investment and management of large sums, which requires protection of principle while obtaining a reasonable return on the investment of the lump sum award in order to continue to adequately compensate for the injury. According to the results of a study published in the April 28, 1980 issue of "Business Insurance," ninety percent (90%) of all major windfalls, whether in the form of sweepstakes, lotteries or court settlements, have been squandered within five (5) years. Structured settlements prevent this.

The benefit to insurance companies of paying large awards in periodic installments is obvious. Through structured settlements, insurance carriers can provide a large future payout without an outlay of a huge lump sum. Providing payments through an annuity may substantially reduce the cost of providing financial security and independence to the injured parties or the survivors of a decedent.

Clearly, use of periodic payments represents a positive approach to satisfying large awards in that it benefits the claimant and the defendant, while compromising neither parties' rights or obligations.

California also has enacted a two-hundred fifty-thousand dollar ($250,000) limitation on noneconomic loss. It has long been recognized that "compensation" for pain and suffering leads to unpredictable and apparently arbitrary results in the judiciary. The limitation on noneconomic loss has enabled insurance companies to factor in a ceiling when establishing reserves, which permits the company to set its reserves more accurately and more cost effectively. This directly contributes to stabilizing premiums.

Perhaps the most important provision of AB 1XX is the right of the defense to advise the jury of the true extent of the plaintiff's financial loss by admitting into evidence the full amount of his loss as offset by the amount of compensation he or she received through other sources, i.e., insurance benefits. In return, the plaintiff is entitled to show the amount of premium dollars paid for access to these collateral sources of reimbursement.

The abrogation of the collateral source rule in medical malpractice actions was intended to reduce the size of malpractice verdicts by barring recovery for the portion of the loss for which the plaintiff had been compensated through collateral benefits. Industry commentators suggest that permitting information about collateral benefits translates to an eleven percent (11%) decrease on what would otherwise be the appropriate medical malpractice premium rate.

California also limits attorney's contingency fees, having established a sliding scale geared to the total amount of a judgment. The plaintiff thereby obtains more on a verdict or settlement than would otherwise be available. Whether or not this aspect of AB 1XX has had a favorable impact on the financial profile of medical professional liability insurance carriers in California is not known at this juncture. Suffice it to say, that particular aspect of AB 1XX has been the target of vigorous constitutional challenge.

Current Developments / Potential Professional Liability Exposure

In 1983, the California Legislature approved the right of third-party payors to contract directly with patient groups and individual physicians, creating Preferred Provider Organizations (PPO). Through the PPO, a given health care provider is guaranteed a patient base in return for charging a discounted fee for services. Underlying the PPO concept are goals of cost containment and, arguably, a departure from the current standard of care which have defensive medicine (i.e. costly) at its heart.

Any thinking person believes the cost containment in health care is laudatory and should be encouraged. However, in California, there is an apparent gap between the Legislature's approval of a system based on reimbursement for fewer procedures and shorter hospital stays as compared to the judicial standard, which contemplates thoroughness in diagnosis and treatment, also known as defensive medicine. Thus, physicians in California are stuck in the hiatus. If a PPO patient is injured as a result of cost containment factors overriding defensive medicine (i.e., he or she did not have access to as many tests as private patients have had in the past), there is a real possibility that physicians and their insurance carriers will bear the burden of the gap between the PPO enabling legislation and the standard of care established by case law.

Similar issues arise from the advent of diagnosis related groups (DRG). As you know, Medicare patients will now be assigned a DRG and reimbursement will be limited to that diagnosis rather than individual patient profile. In California, this will result in the development of three (3) different philosophies of care within one (1) hospital while the judiciary recognizes only one (1) standard of care. For example, for Medicare DRG patients, physicians and hospitals will be encouraged to discharge those patients as quickly as possible and prescribe as little as possible. For Medi-Cal patients, reimbursement is on a per diem basis, so it is likely that lengthy hospitalizations will be tolerated, if not encouraged, but physicians will be discouraged from prescribing the extent of tests and procedures typical of the practice of defensive medicine. Compare these two (2) patient groups to the fully insured individual, where payment is cost plus; it is likely that private patients will continue to be treated in accordance with the defensive standard, remaining in the hospital for as long as a physician feels it will benefit the patient and any test or procedure which might be helpful will probably be prescribed. Without making a value judgment about this difference in treatment, it is obvious that problems will arise concerning deviation from the applicable standard of care.

Despite the imprimatur granted the DRG system and PPOs by the United States and California Legislatures respectively, there has been no companion legislation enacted regarding the appropriate standard of care. There is reason to believe that if three (3) patients with the exact same illness are in the hospital and they receive three (3) different levels of treatment based on their third-party payor, a court will find liability on the part of the hospital and the physician if the patient is injured by receiving less care due to a lower reimbursement level.

We believe it is important for the Legislature to consider this discrepancy and enact ameliorative legislation to address it.

Conclusion

NORCAL greatly appreciates the opportunity to provide testimony to Senator Hatch and the Committee on Labor and Human Resources and thanks the Committee for inviting us to express our views. Should additional information be valuable to the Committee in its exploration of the current medical malpractice climate and the development of ameliorative legislative proposals, please be assured that NORCAL's resources remain available.

Respectfully submitted,

L. Savannah Lichtman

L. Savannah Lichtman

Senator QUAYLE. Thank you very much.

Let me ask each of the panelists, do you believe that we're getting back, in the mid-1980's, where we were in the 1970's as far as the problem with the medical malpractice? Are we going in that direction, Mr. Rolig? Do you want to answer first?

Mr. ROLIG. Senator Quayle, I believe that we're in a different position at this time. I think each of us, and perhaps the prior panel as well, alluded to the fact of what we call the availability crisis of 1975. That was a period of time when health care providers, perhaps, couldn't purchase insurance if they wanted to. There were no carriers available.

At this period of time we see not only in this line of insurance, but in all lines of insurance, a great influx of capital into our business. Accordingly, there is a lot of competition there and, for this particular line, a lot of competition can mean anywhere from three to five carriers within a given State or jurisdiction. We find that there is a great deal of competition, so the insurance is available.

I also have a problem with the hue and cry of crisis because that tends to suggest a number of lemmings marching to the sea; but it is a fact that malpractice insurance is expensive, and it is a fact that it's going up. At what point in time we reach that fence or that gate where you say "we can no longer afford," that's the issue that I think we're addressing. I have seen some statistics, and I wish I had had that information available for you today, as to where they came from; but as to a doctor's income, perhaps three and a half percent of his income goes toward malpractice insurance premiums. That does not seem excessive to me vis-a-vis other insurance purchasers.

So I guess what I'm saying is that I don't think we've reached that affordability situation yet, but all of us, I think, see a trend in that fashion.

On that affordability issue, and I'll ask Mr. Steffes to respond, I have been told—and I think it was in the written testimony, I think by Professor Danzon earlier—they say that the percentage of money that a physician is paying for malpractice insurance, the percentage of income, is about the same as it was in 1970. There has not been any real increase in percentage, and that gets into your affordability issue. That would be in synch somewhat with your reference to three and a half percent. It's across the board. I think you've seen big increases in obstetrics and some of the other specialties, but across the board they're paying about the same as they were in 1970. Mr. Steffes?

Mr. **Steffes**. I think that's a fair statement. But in answer to your question to compare 1984 with 1976 and what is going to impact this and what is the bottom line, you have a much more sophisticated, litigous patient out there now than you had then. The day is over when you don't sue old Dr. Sam; mainly because they don't see Dr. Sam half of the time, and they don't care who they're going to sue. They're going to sue somebody. Also, you have a much more prestigious specialty law firm now that is directing your large malpractice case. You no longer see in your critical cases, as a general rule—there's always exceptions—where the practicing lawyer like you or I were to take on a large malpractice case. We would be the finders, so to speak, and then we would refer it to one of these large law firms that specialize in medical malpractice. They have a team of expertise, not only in the legal field but oftentimes in the medical, / MD, / JD, et cetera, that put together a very, very sophisticated, in-depth case that you'd better be prepared to defend to the hilt. You're talking about defending these cases 4, 5, 6 weeks before a jury that, in some of our areas, you're lucky if they have a high school education. The trauma and the emotions oftentimes outweigh what the result is.

So in trying to build this into the financial structure you have to weigh that very carefully. Our figures are consistent, I think, with both panelists that the frequency is increasing and the severity is increasing, so this all goes into the cost. It is a fact, I think, in 1984 that all of us are involved in increasing our rate structures on a realistic percentage to not only reflect what has taken place in the past, but what we can anticipate taking place in the future so that we avoid the so-called crisis and continue to maintain a market. I think that is the thrust of many of us now, Senator, is to maintain a market at a reasonable cost and not to have to come out with, "All right, we get 100 percent increase or we bail out." That is what happened, essentially, in the mid-1970's.

But I have to admit to you that there is malpractice out there, and we're very concerned. You talk about your HMO's and your PPO's. What is the discipline going to be in that setting compared to the discipline that's in the hospital setting? It's true 80 percent of your malpractice cases take place now in the hospital, and you heard references at the last committee that this may be shifted.

But what discipline is going to be shifted with it? What safeguards? Who's going to be the sergeant at arms to watch over that practitioner, that nurse, et cetera? These are great concerns and we don't have the answers, I don't think, as we sit here today to project this, but we must anticipate it.

Senator QUAYLE. Ms. Lichtman?

Ms. LICHTMAN. Thank you.

As far as your comment about the percentage of income that goes to medical malpractice premiums, I think that that is accurate but it's important to know that right now, there is generally a claims made policy throughout the United States as opposed to an occurrence policy. The claims made policy, as you know, has very much lower cost up front and then it escalates when a physician leaves the insurance carrier. He has to pay a fairly large lump sum in order to translate that coverage, if you will, to commensurate coverage with occurrence. So part of the savings that we've seen in premiums for this kind of coverage has to do with the difference in the type of coverage that's being offered to physicians from many companies.

As far as what you've observed or asked concerning a crisis, I agree with what Mr. Steffes has said. The crisis will be of affordability rather than availability. In California we have a half dozen companies competing with one another; obviously, that helps in keeping costs low. But according to statistics from the Insurance Information Institute, 1983 had 100 percent increase over 1982 as far as medical malpractice losses are concerned. And '84 is following that trend. So the costs will increase, and that may well translate into a crisis.

Senator QUAYLE. Let me ask one final question. The last panel hit upon the idea of private contracts as a vehicle to supplement the tort litigation, and they certainly espoused the idea that it would be a potential savings and a much more efficient way, and maybe even a tradeoff would be a more expeditious payment.

Is this a good idea, and do you encourage its promotion, or would you want to put a little cold water on the idea? Mr. Rolig?

Mr. ROLIG. I think that Professor Havighurst perhaps was referring to something which I just read shortly before I came here, and that was a decision, I believe, in Savannah out in California, about the Kaiser plan which, as you know, is a prepaid health plan. And in that prepaid health plan contract a patient, in essence, was allowed to contract for—that they would not go to court with their claims, but that the prepaid health plan would make that good. I can't give you any further details, but I would suggest that it is in that prepaid health plan, which would be like an HMO or some other such aspect, that that could possibly exist.

I see much greater difficulty in the independent practitioner-type of role coming forth, and perhaps not. I frankly haven't given that a great deal of thought because I guess maybe I'm one of those lawyers that is negative, much like Professor Havighurst said, given our training——

Senator QUAYLE. But we're given the general idea. If in fact you could get the idea across that these could be enforced, and they would be equitable and constitutional—you can't waive gross negligence. That's ridiculous.

Mr. **Rolig**. Yes.

Senator **Quayle**. I think as a tradeoff on the waiving of the right to trial by jury, ultimately, I suppose that you could get in a court of equity and see what balancing factors work; and maybe not. Maybe the Supreme Court. would interpret such legislation with a strict constitutional interpretation, which would mean that you just simply couldn't waive that right. The decision could be under duress—you know, or you could cite all sorts of other reasons. It struck me as not just a theory but something that we ought to really seriously give thought to.

Mr. **Rolig**. I think it's something to address. One of the things that might be of some significance, I guess, in looking at that is the decisions with respect to binding arbitration. A lot of those binding arbitration agreements were put on the front end of hospital admissions wherein you agreed, if something happens, to submit to binding arbitration. Many of those in many States were thrown out, the rationale being that the person did not have the ability to judge, going into the hospital, what it would be like coming out, that you have to have an opportunity to reject that after treatment. Those were some of the judicial decisions, and I think that there's some degree of likeness between those kinds of contracts. I think that's certainly something that needs to be explored.

Senator **Quayle**. Mr. Steffes?

Mr. **Steffes**. We explored the California plan back in 1976 and 1977, and Linda, I think you were in Pennsylvania at the time, and we've worked on a similar program where the patient executes a document as you go in, and you've got 30 or 60 days to revoke it, et cetera, and the arbitration process is set forth.

In theory it was very fine. On paper it looked good. The only problem was, we couldn't even get it strong enough legislative support to get it into committee and to get the thing off the ground.

Now, we think the concept has merit, and I think we've reached the point that we have to sit down at the drawing tables and explore all of these things and tie it in to an arbitration system that is workable and just is not duplicative of expense and used as a fishing expedition to build a case and then start all over. Otherwise, we're just compounding the problem of expense. We're rapidly reaching the point where the expense is equalling or exceeding the indemnity dollar paid to the patient, and I think that is entirely wrong. The system cannot afford it. But I think if we could tie it in with a mandatory arbitration system that is not de novo, I think there is a possibility that it could work and with all of the constitutionality safeguards that are built into it.

Senator **Quayle**. Do you envision this mandatory arbitration system being at the Federal level, or would this be——

Mr. **Steffes**. Well, we tried it, Senator Quayle, in Pennsylvania and they had over 3,400 cases bogged down and—pardon the expression—they were bogged down in the bureaucracy. We just couldn't get them moving. We couldn't get the panel; they had a seven-member panel, which was unworkable, then they reduced it to a three-member panel and it still didn't get going, and finally the court, with justification, said this is not due process. You're sitting there 3, 4, years, you haven't had your case up, so it was declared unconstitutional.

I think if the arbitration system is given clout support, authority, that it could work. It is an avenue, because, unfortunately—we have a fine judicial system but innately a judge for the most part, and I hear this from my friends, judges, they hate malpractice cases. They're too long and they're too involved and they're too complex. We see this where the plaintiff's attorney uses a shotgun approach and names everybody, and the expense of just getting other defendants out is astronomical; and most of the judges are afraid to take the bull by the horns and dismiss them. And there we are with a circus for 4 or 5 weeks where we spend hundreds of thousands of dollars on defense; if we win, it's appealed. If we lose, it's appealed. And it goes on and on and at the same time the poor patient is laying there and isn't compensated. I think somehow along the line we should develop a good, workable arbitration system or combination of some system that we can relieve the courts, at least on the routine cases, the run-of-the-mill cases.

Senator QUAYLE. Ms. Lichtman?

Ms. LICHTMAN. I'm a bit skeptical about the success of private contracts. We have had precedent in California where the courts have thrown out a patient's agreement to arbitrate a claim, saying that that patient didn't really understand which rights she was waiving. I suspect that the court would continue in that posture if a patient found that he or she was upset with the agreement in advance to arbitrate.

So given those caveats, I am not really certain about the success of a unilateral contract in California.

As for arbitration, of course I believe it could be successful, but I also perceive a tendency on the part of arbitrators to split the baby, if you will. Arbitrators are generally selected on the basis of the satisfaction of both sides with their decisions; and in order to be satisfactory to both sides, there does appear to be a tendency to render an award, even if the liability is questionable.

So I'm not 100 percent optimistic about arbitration either. My personal preference is for the traditional judicial system with court reform measures that have been discussed here. If we could get some way to have them accepted from a constitutional perspective in the States.

Senator QUAYLE. What court reform measures are you speaking of?

Ms. LICHTMAN. The limitations on pain and suffering; the abrogation of the collateral source rule; periodic payments rather than lump sum awards; limitations on the time of discover, those kinds of things. Many of those concepts are embodied in H.R. 5400. The main thing, as far as we're concerned, is the no-fault approach. There's been a traditional bias against that, and for good reason.

Senator QUAYLE. So, basically, you're talking about the limitations on pain and suffering, so you're talking about caps?

Ms. LICHTMAN. Yes, very much like the Indiana legislation.

Senator QUAYLE. You would propose Federal legislation along the lines of the Indiana legislation?

Ms. LICHTMAN. Yes.

Senator QUAYLE. OK.

Thank you all very much.

The next panel is Dr. Jim Davis, Elvoy Raines, John R. Ball, and John S. Hoff.

Dr. Davis?

STATEMENT OF JAMES E. DAVIS, M.D., SPEAKER OF THE HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY ROSS RUBIN, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION, AMERICAN MEDICAL ASSOCIATION

Dr. DAVIS. Good morning, Mr. Chairman. I am James E. Davis, M.D., a physician in the practice of general surgery in Durham, NC. I serve as speaker of the house of delegates of the American Medical Association. I also serve as president of the North Carolina Medical Mutual Insurance Co., our captive company formed in 1975. With me today is Ross Rubin, who is director of AMA's Department of Federal Legislation.

Mr. Chairman, the American Medical Association believes that professional liability costs, and the resultant effect on the practice of medicine, are among the most serious concerns now facing medicine. We are extremely concerned at escalating professional liability costs and the impacting cost to consumers of handling professional liability claims under our present tort system. The American Medical Association and State medical societies throughout the country have been very active over the years in working with legislators, lawyers, and insurers in developing solutions to problems in the professional liability area, and these activities are summarized in my full statement.

The American Medical Association also took a leadership role in encouraging physician groups to form medical liability insurance companies; and by establishing the American Medical Assurance Co., [AMACO] which specializes in reinsurance for physician-owned, medical society-created medical society liability insurance companies.

Mr. Chairman, the AMA is now initiating a major effort to encourage all State medical societies to form coalitions supporting tort reform in each State. These coalitions will represent numerous interests adversely affected by present escalating tort liability costs, and will address such issues as reform of laws governing products and professional liability.

Recent trends in professional liability indicate an increase in the number of claims and adjudicated awards. The average incidence of professional liability claims has risen from 3.3 claims per 100 physicians prior to 1978 to 8 claims per 100 physicians in the period 1978–83. No segment of litigation has had a more rapid growth through the past 15 years than claims emanating from health care in the United States. There are many reasons for this increase. American medicine has experienced a dramatic improvement in medical technology. The complex modern armamentaria of scientific tests, procedures and treatments have been responsible for what is truly miraculous medical advances. Quite naturally and understandably, each medical breakthrough has increased the expectations of the public with respect to what constitutes good health care. Many of us now expect perfect outcomes from every medical intervention, regardless of the complexity of the treatment or the severity of the patient's condition. When the result is anything less than perfection, increasingly people will seek legal remedies.

It is important in discussing the issue of professional liability to remember that when an injury occurs as a result of the negligence of the practitioner, the patient should be adequately compensated for that injury. Unfortunately, the existing tort system does not seem to be reaching these goals with only 20 cents of every premium dollar going to an injured claimant.

Many groups have been attempting to isolate the amount of defensive medicine and, in fact, our own Committee on Professional Liability has projected the possibility of over $15.1 billion in costs related to defensive medicine. The problem with all of these estimates, including our own, is that there is no clear definition of what constitutes defensive medicine. There are numerous subjective determinations that go into whether a particular item would be classified as defensive medicine.

In a progressing field such as medicine, accepted standards of practice are continually evolving. New knowledge about disease causation and treatment of illness and injury are constantly being made available and technology continues to advance the state-of-the-art in medical practice. Dissemination of new knowledge and introduction of new technology is not uniform throughout our country; moreover, medical practice still involves a substantial amount of subjective professional judgment. While we would all like to think of medicine as an exact science, in practice such uniformity is impossible. Each patient brings to the physician a unique set of attributes and conditions; what is successful for one patient may not be adequate for another.

When a physician performs an examination or orders a test, one purpose may be to shield against potential liability. Another likely purpose is to provide his patient with the definitive benefit of all available medical technology and resulting information. As an example, two physicians faced with a child with a head injury may both order an x-ray—one to "play it safe and make sure nothing is wrong," and the other to "avoid exposure to liability." Regardless of the motivation for ordering the test, if the scan shows a significant abnormality, the test is deemed to be necessary. On the other hand, a negative finding may in retrospect characterize the examination or test as defensive medicine regardless of the motivation.

Mr. Chairman, the issue of defensive medicine raises numerous questions that need to be answered. We at the American Medical Association intend to continue our efforts to better define the parameters of defensive medicine.

Clearly, whenever addressing an issue such as professional liability and defensive medicine, the threshold question is whether or not the issue dealt with is appropriate for Federal intervention. This question is even more pertinent in an area such as professional liability tort reform which has traditionally been dealt with at the State level. We remain hopeful that the States will continue to be active in this area and develop programs responsive to their individual needs. The American Medical Association will support and enhance these efforts. We must caution Congress against adopting Federal legislation applicable nationwide to deal with local problems.

Mr. Chairman, we know that it is our mutual objective that persons should receive adequate compensation for acts of malpractice, and that the bulk of the premium dollar go to the injured person as compensation and not be diverted to others. We will continue our efforts and activities with State medical societies to effectively deal with professional liability matters within the States.

Mr. Chairman, we appreciate the opportunity of being here this morning. We look forward to any questions which you might have, sir.

[The prepared statement of Dr. Davis follows:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the

Committee on Labor and Human Resources
U.S. Senate

Presented by

James E. Davis, M.D.

RE: Defensive Medicine

July 10, 1984

Mr. Chairman and Members of the Committee:

I am James E. Davis, M.D., a physician in the practice of general surgery in Durham, North Carolina. I serve as Speaker of the House of Delegates of the American Medical Association. With me today is Ross Rubin, Director of AMA's Department of Federal Legislation.

The American Medical Association is pleased to offer its views on the subject of Defensive Medicine.

INTRODUCTION

Mr. Chairman, I am sure that you and other members of Congress have been hearing from your physician constituents and others who are concerned about the increased costs of professional liability insurance and the increased incidence of claims brought against health care providers.

Premiums for medical professional liability coverage have been increasing at double digit rates in recent years with no real expectation of let up. The issue of professional liability and costs related to such cases have become more controversial and serious than at any time since the professional liability crisis of the mid-1970s. This concern, especially when combined with the heightened concern over aggregate health care cost increases generally, has generated renewed Congressional interest in the area of medical professional liability.

Legislation has been introduced in both the Senate and the House (S. 2690 and H.R. 5400) directed at dealing with medical professional liability issues. While the AMA does not support this legislation, we believe that the bills do provide an important focus for national discussion of the issue.

Mr. Chairman, we appreciate the actions of this Committee in providing an opportunity for timely discussion of this critical issue. The American Medical Association believes that professional liability costs and the resultant effect on the practice of medicine are among the most serious concerns facing medicine. We are extremely concerned by escalating professional liability costs and the impact and cost to consumers of handling professional liability claims under the present tort system, and the AMA has been actively involved in developing and pursuing various approaches to this problem.

The American Medical Association and in particular the state medical societies throughout the country have been very active over the years in working with legislators, lawyers, and insurors in developing solutions to problems in the professional liability area. In the mid-1970s, when the lack of availability of professional liability insurance had reached a crisis level, the AMA took a leadership role in encouraging physician groups to form medical liability companies. To assist these physician-owned companies, the AMA established the American Medical Assurance Company (AMACO) which specializes in reinsurance for physician-owned/-medical society-created medical professional liability insurance companies. Incorporated in 1975, AMACO commenced business in June of 1976. AMACO now has outstanding reinsurance coverage of approximately $5 million for 17 physician-owned companies in 17 states representing 55,000 physician insureds. Also in the mid-1970s, the AMA developed model state legislation calling for a number of professional liability tort reforms.

Recent AMA Activities

Mr. Chairman, the AMA is now initiating a major effort to encourage all state medical societies to form coalitions supporting tort reform in each state. These coalitions will represent numerous interests adversely affected by present escalating professional liability costs and will address such issues as reform of laws governing product and professional liability and development of appropriate public education programs regarding the impact and cost to consumers of present liability laws. We believe that these coalitions for tort reform will provide an excellent opportunity for public and private sector interest groups that share a common concern over liability costs to develop and pursue meritorious tort reforms. It should be noted that this coalition activity will not be limited merely to medical professional liability issues, but will involve product liability as well. In addition, AMA will be focusing greater staff resources towards dealing with the evolving professional liability problem as it affects the practice of medicine in America.

A year ago the AMA appointed a special Committee on Professional Liability. This Committee developed a report concerning the direct and indirect costs of professional liability. The Committee continues to study trends in reported claims and premium rates and evaluates the impact of remedial tort reforms on claims and rates and will recommend promising avenues for solutions.

Mr. Chairman, the AMA and over 150 other organizations are currently engaged in the development of the Health Policy Agenda for the American People. One Work Group on this important project deals with the issue of professional liability. Although the project is not yet completed, the participating groups have adopted the following principles bearing on this subject: The primary responsibility of health care professionals should be the provision of high quality care by the most efficient means (Principle 5-5). There should be fair and adequate compensation for injuries that occur as a result of deviations from acceptable levels of professional and institutional care (Principle 5-5b). The Health Policy Agenda will soon develop policy recommendations in the area of professional liability, guided by these principles.

The Malpractice Problem

Recent trends in professional liability indicate an increase in the number of claims and adjudicated awards. The average incidence of professional liability claims has risen from 3.3 claims per 100 physicians prior to 1978 to 8.0 per 100 physicians in the period 1978-1983. According to AMA's Committee on Professional Liability, "no segment of litigation has had a more rapid growth during the past fifteen years than claims emanating from health care in the United States."

There are many reasons for this increase. American medicine has experienced a dramatic improvement in medical technology. The complex modern armamentaria of scientific tests, procedures and treatments have been responsible for nearly miraculous medical advances. Quite naturally, each medical breakthrough has increased the expectations of the public with respect to what constitutes good health care. Many of us now expect perfect outcomes from every medical intervention, regardless of the complexity of the treatment or the severity of the patient's condition. When the result is anything less than perfection, increasingly people will seek legal remedies.

In addition, the amount of publicity given to large jury awards and public awareness of plaintiffs' rights and remedies has contributed to an increase in professional liability claims. For that matter, there is an increase in litigation generally in our nation. In the professional liability area this trend may be accentuated as we see more extensive education and training of lawyers in the handling of medical professional liability claims. Contributing to the increase in the amounts claimed are additional factors including general economic inflation and the escalating costs of legal defense.

The increased number of claims, together with higher dollar awards, has contributed to the increase in health care costs. Direct costs include physicians' costs of premiums paid for professional liability insurance. There is a great deal of variance between professional liability insurance premiums which can be as low as $1,200 per year in Indiana to over $63,000 per year in New York, depending on locality, specialty and type of policy. Other direct costs include resources required to underwrite MD-created companies; hospital costs for patient liability premiums; costs of risk management programs by physicians and hospitals; the cost of legal counsel employed by health care providers; and indirect costs attributable to defensive medicine.

Fair Compensation for Injury

It is important in discussing the issue of professional liability and legislation dealing with this subject to remember that when an injury occurs as a result of the negligence of a practitioner, the patient should be adequately compensated for the injury. Through professional liability actions, patients who claim injury as a result of a deficiency in the health care provided by a qualified professional can seek restitution for their injuries. The existence of potential liability is also one means of encouraging services that meet an appropriate standard of care.

Mr. Chairman, unfortunately the existing tort system does not seem to be reaching these goals. As evidence of this, only 20 cents of every premium dollar goes to an injured claimant. A higher percentage of premiums should go to compensate injured parties.

Defensive Medicine

Mr. Chairman, the stated purpose of this hearing is to discuss "defensive medicine." There is a growing concern that "defensive medicine" is adding significantly to the costs of medical care. Many groups have been attempting to isolate the amount of "defensive medicine" and, in fact, our own Committee on Professional Liability has projected the possibility of over $15.1 billion in costs related to "defensive medicine." The problem with all of these estimates, including our own, is that there is no clear definition of what constitutes defensive medicine. The HHS Secretary's Commission on Medical Malpractice has defined the term to mean "the alteration of modes in medical practice, induced by the threat of liability, for the principal purpose of forestalling the possibility of law suits by patients as well as providing a good legal defense in the event such law suits are instituted." While this definition appears clear on its face, there are numerous subjective determinations that go into whether a particular item would be classified as "defensive medicine."

In a progressing field such as medicine, accepted standards of practice are continually evolving. New knowlege about disease causation and treatment of illness and injury are constantly being made available and technology continues to advance the state-of-the-art in medical practice. Dissemination of new knowledge and introduction of new technology is not uniform throughout the country. Moreover, medical practice still involves a substantial amount of subjective professional judgment. While we would all like to think of medicine as an exact science, in practice such uniformity is impossible. Each patient brings to the physician a unique set of attributes and conditions. What is successful for one patient may not be adequate for another.

When a physician performs an examination or orders a test, one purpose may be to shield against potential liability. Another likely purpose is to provide the patient with the definitive benefit of available medical technology and resulting information. For example, two physicians faced with a child with a head injury may both order an X-ray —one to "play it safe and make sure nothing is wrong," and the other to "avoid exposure to liability." Regardless of the motivation for ordering the test, if the scan shows a significant abnormality, the test must be deemed necessary. On the other hand, a negative finding may in retrospect characterize the examination or test as "defensive medicine" regardless of the motivation. The procedure resulting in a positive finding should not be arbitrarily ruled out prospectively by a treating physician having responsibility of the welfare of the patient merely because the act may also be defensive in character.

Mr. Chairman, the issue of defensive medicine raises numerous questions that need to be answered. We intend to continue our efforts to better define the parameters of defensive medicine and we commend this Committee for its efforts to highlight this important concern.

Federal vs. State Solutions

Clearly whenever addressing an issue such as professional liability and defensive medicine, the threshold question is whether or not the issue dealt with is appropriate for federal intervention. This question is even more pertinent when it comes to an area such as professional liability tort reform which has traditionally been dealt with at the state level. We believe that one of the most fundamental criteria for development of federal legislation is the existence of a problem throughout the country. In the case of professional liability, the evidence is clear that there are some states where there are serious problems of high insurance premiums and physicians leaving their specialties, yet, there are many other states that do not have similar problems. We remain hopeful that states will continue to be active in this area and develop programs responsive to their needs. We must caution Congress against adopting federal legislation applicable nationwide to deal with local crises.

CONCLUSION

Mr. Chairman, we appreciate your efforts to highlight the issue of professional liability and its effect on health care costs. We know that it is our mutual objective that persons should receive adequate compensation for acts of malpractice. We believe that it is important that the bulk of the premium dollar go to the injured person as compensation and not be diverted to others. We will continue our efforts and activities with state medical societies to effectively deal with professional liability matters within the states. We are making a major commitment of time and resources to those efforts in the hope of developing solutions to these problems that will best serve our patients. The AMA is committed to work with state coalitions, our Committee on Professional liability, the HPA project, and other staff initiatives. We will be pleased to keep this Committee informed of our activities.

At this time, Mr. Chairman, I would happy to respond to any questions from the Committee.

1473p

Senator Quayle. Thank you.
Elvoy Raines.

STATEMENT OF ELVOY RAINES, ASSOCIATE DIRECTOR, DEPARTMENT OF PROFESSIONAL LIABILITY, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Mr. Raines. Senator Quayle, I represent the American College of Obstetricians and Gynecologists, an organization of about 24,000 OB/GYN's from around the Nation. Our organization represents probably 95 percent of such specialists in the country.

After hearing the first panel today talk about the absence of a crisis, the fact that perhaps this is a local aberration and that this is not a national problem, I felt a lot better and thought perhaps I should go back to the office and call up these 24,000 and tell them that we don't have a problem. But I don't think that they're going to believe me; I don't think they would believe any of the panelists that have testified thereto.

The problem that OB/GYN's have is a continuation of what they would term the "crisis of the 1970's" but it has changed from one of availability to one of affordability. I would suggest that perhaps we may see a return to a crisis of availability at some point as insurance companies grow more concerned about who is an insurable risk and who is not.

But we have done our own studies of what kind of impact this problem is having on obstetricians and gynecologists and the scope and manner of their practice, and our study reveals to us that it is forcing them to make changes, that they are reacting as any human being would in trying to put some distance between themselves and the frequency and severity of lawsuits.

Let me explain a little about the frequency and severity of lawsuits for OB/GYN's. It has more than tripled in terms of numbers of suits in the last 5 years. So the averages that you hear for increases in the frequency of lawsuits against physicians, those are averages for physicians all across the country regardless of whether they are specialists or not. But in this surgical specialty the increase has been more than three times in the last 5 years. The severity of claims has increased as well, and now the average indemnity, the average settlement value in an OB/GYN case is over $120,000. The average verdict in a court case is over $900,000. In your own State of Indiana, the verdict expectancies are running about 15 percent above the national average; so even in that State, which has a representative kind of State tort law, the claims experience is up and certainly the average indemnity is way up.

The reaction of physicians is that they do less of some things and more of some things. They do less high-risk obstetrics and gynecology, we have found from our own study and from comparable studies around the country. In some cases they are completely eliminating obstetrics, getting completely out of the field. Around 9 percent have nationwide, but in Florida the percentage is over 20 percent. In fact, we have heard from some studies there that even family physicians are not doing obstetrics in Florida as a result of the threat of lawsuit. So it's not just the specialty of OB/GYN.

They do more of some things. They do more testing. They do more monitoring in cases. We found in our study that around 75 percent more of such protective actions were taken; things trying to anticipate where they might miss a diagnosis or where they might miss something that would later hang them up in a lawsuit. Arguably, this defensive medicine does not prevent lawsuits and probably does not make them any more defensible. But certainly, we can all conclude that it increases health care costs. If we're going to get a grip on health care costs, we've certainly got to respond in some fashion here.

The reason that this is a national issue for surgical specialties and for the medical profession, too, is because we are trying to make compatible the laws of the land, the application of the legal profession's view of negligence to that of medicine. And I can tell you from experience that a lawyer's definition of negligence is a world apart from a physician's definition of negligence. And somehow, we're going to have to make them more compatible.

This is a national health policy issue because it has an impact on the availability and accessibility of care, as we have demonstrated in our own survey; arguably it has an impact on the quality, and most certainly has an impact upon the costs, by whatever estimate that might be. It is appropriate that the Congress is expressing interest in this problem. We certainly applaud that. There are no simple and quick solutions, but certainly you're going to have our cooperation in examining the issue and searching for those solutions.

Thank you.

[The prepared statement of Mr. Raines follows:]

STATEMENT

of the

American College of Obstetricians and Gynecologists

Presented by

Elvoy Raines

on

Medical Professional Liability

before the

Committee on Labor and Human Resources

United States Senate

July 10, 1984

The American College of Obstetricians and Gynecologists welcomes this opportunity to share with the United States Senate our grave concern for the impact that medical professional liability is having upon the availability, accessibility, quality and cost of health care. It is a phenomenon of modern medicine, a condition of medical practice which increasingly is experienced by all physicians but most graphically by the surgical specialties; and, the aberrant consequences of physicians' being held to unrealistically high expectations under the existing tort system threaten the very foundation of American medicine. It is time for a national awareness and understanding of this issue so that we might recognize the immediate as well as long range implications, and attempt to formulate reasonable and effective responses.

The effort to find reasonable and effective responses, however, is not easy. The ACOG was among the first medical organizations in the country to attempt the finding of solutions, and after years of effort we are still frustrated by the enormity and complexity of the problem. But we have learned a great deal, and we are here to share such information with the Committee and the Senate in the sincerest hope that we might act jointly to find solutions that are fair to patients and protective of their interests while adjusting in a realistic fashion the weight of accountability currently carried by the medical profession.

There was a much-publicized medical professional liability "crisis" in the 1970's. It occurred for a variety of reasons, at least some of which are yet uncertain, but the impact was substantial. Between 1935 and 1975 -- in that forty-year period -- 80% of all medical malpractice lawsuits were filed in the final five years of that period. There was a sudden blossoming of litigation, a burst of claims which had not been anticipated by insurance carriers. The carriers were unprepared, under-reserved, and the effect of such massive litigation was to drive many carriers out of the medical malpractice market. It simply became impossible to purchase insurance coverage in some states. For that reason, over 25% of obstetricians in Florida and California have been without liability insurance of any kind at some point.

Hastily, states reacted. Over 300 state statutes were passed in an effort to stem the tide of lawsuits. Patient compensation funds, joint underwriting associations, mediation panels and other mechanisms came into being. The insurance carriers moved back into the markets, and physicians in many states created their own insurance companies to assure themselves and their colleagues that they would have coverage available at a reasonable price. The "crisis" appeared to subside. I submit, Mr. Chairman, that in fact it did not. Perhaps it was in a period of remission, but it never went away.

Today the crisis is not one of insurance availability, but rather one of affordability. And that is caused by the coninuing trends in the frequency and severity of lawsuits. In the last five years, the frequency of lawsuits against physicians has more than doubled; for obstetricians and gynecologists, we know that it has more than tripled nationwide. In some states, the likelihood of being sued if you are an Ob-Gyn is greater than 25% per year.

Nationally, 60% of Ob-Gyn's have been sued; 20% have been sued three or more times. In New York state, 48.8% of Ob-Gyn's have been sued three or more times. Naturally, when insureds are sued, the insurance carriers experience losses, even in cases where the claim is dropped, and so they raise their premium levels as the frequency and severity of lawsuits increase. Today in New York State, therefore, some Ob-Gyn's pay in excess of $70,000 per year for insurance. And New York is not an isolated rarity, but rather it is representative of the direction being taken throughout the United States.

In Indiana, for instance, average awards are 15% above the national average; in Massachusetts, 19% above the norm; and in Florida, 20% above the norm. But lest we conclude that this is a problem endemic to the populous or industrialized states, we should note that Iowa is also 19% above the national average.

Million-dollar awards are contributing to the problem. Forty-three percent of all million-dollar verdicts are in products liability cases and medical malpractice cases. There have been 41 such verdicts in Pennsylvania, 15 in New Jersey, and 169 in Florida. There have been 219 million-dollar verdicts in New York, the state which leads all others in such awards, accounting for 16% of all million-dollar verdicts. In order of frequency of million-dollar verdicts, the ten leading states are: New York, California, Florida, Texas, Michigan, Illinois, Pennsylvania, Missouri, Arizona and Minnesota. As people who serve on juries grow more accustomed to hearing of million-dollar verdicts, they will grow more comfortable in making such awards, and the press expansively reports such cases, while rarely featuring the fact that physicians are found innocent of liability in most instances. There have been 196 million-dollar verdicts in medical malpractice cases. The frequency of medical million-dollar verdicts has grown from 3 in 1975, to 20 in 1980, and finally to 45 in 1982. And now there are more than 4 million-dollar verdicts in personal injury cases per week.

The average indemnity in medical malpractice cases now stands in excess of $120,000. That is the average settlement cost. Average awards were $962,258 in 1982, when there were 234 verdicts in favor of plaintiffs.

The ACOG measured the impact of the threat of lawsuits and the actual experience of Ob-Gyn's with claims and found that the more physicians fear or are named in lawsuits, the more likely they are to change the scope and manner of their practice. This "change" is popularly known as "defensive medicine." They might quit doing obstetrics entirely, as more than 20% in Florida have done; or they will limit their obstetrical practice, doing less high risk obstetrics or handling fewer obstetrical cases. They are selective about their patient population, or they might eliminate or limit their gynecologic surgery caseload. The clear result is that it could become difficult for women in some areas to find an adequate selection of specialists to care for them. Obviously that will have an impact upon the availability and accessibility of care, and arguably upon the quality when specialists are less involved in solving complex medical problems.

It also has an effect upon the cost of care. In New York, more than 20% of Ob-Gyn's have increased their fees more than 30% in the last two years; in Florida, it is a similar situation. In order to pay skyrocketing insurance premiums, physicians increase their fees more frequently, and by greater increments. The chain of events is clear: more lawsuits are filed; insurance carriers experience more frequent and more substantial losses, even when the cases are dropped; the carriers raise their rates to cover losses; the physicians who must pay their insurance premiums increase fees while changing the way they practice. It takes no great analysis to see that the patient is paying dearly for the current glut of medical malpractice litigation.

But the more subtle "cost" that we bear as a consequence of the professional liability problem is that caused by the practice of "defensive medicine." Estimates of its impact vary, and the frightening aspect of this matter is that reliable figures are almost impossible to determine; we do know the impact upon direct costs of health care have increased as physicians pass through the growing cost of insurance, and we can imagine the significance of physicians' changing the amount of diagnostic testing that they order. In our survey of several thousand obstetricians and gynecologists we found that 76% had substantially increased testing and other diagnostic procedures, 72% were more frequently employing technologies such as monitoring, and 58% were utilizing consultations more frequently.

Some improvements have occurred, especially in the area of informed consent, but physicians believe that they can somehow turn aside the threat of litigation by reacting with more testing, more technology, more this, and more that; in reality, I suspect, they are not effectively diminishing their risk of lawsuit and may perhaps be increasing it. There is no question that this adds to the nation's health care bill.

But what can we expect of physicians? They are human beings who respond as anyone else would: the crisis of professional liability drives them to react, to respond in some fashion that will give them a sense of relief, if not the real thing. We are making a great effort to help physicians turn to a better style of practice, to practicing "defensible" medicine, rather than "defensive" medicine. Defensible medicine is that practice which can be explained, understood, and, if necessary, defended where challenged. But our efforts are not enough, and we must have a public awareness and recognition of the impact that the threat of litigation is having upon the modern practice of medicine -- its availability, accessibility and quality, and its cost. We must find new solutions, and more realistic solutions than simplistic accusations against physicians, or lawyers, or consumers.

Mr. Chairman and members of the Committee, we call upon you to share our concern for assuring the availability and affordability of adequate professional care for all Americans. The American College of Obstetricians and Gynecologists is committed to providing its full support to sincere and reasonable efforts to develop a national policy perspective on this pressing issue.

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Senator QUAYLE. Thank you very much.
John Ball.

STATEMENT OF JOHN R. BALL, ASSOCIATE EXECUTIVE VICE PRESIDENT, HEALTH AND PUBLIC POLICY, AMERICAN COLLEGE OF PHYSICIANS

Dr. BALL. Thank you, Mr. Chairman.

The American College of Physicians is pleased to have this opportunity to appear before you today to discuss some of the issues involved in medical professional liability, but most specifically we'd like to focus on the issue of defensive medicine.

My name is John Ball; I am the associate executive vice president for health and public policy of the College of Physicians. I am both a physician and an attorney, and was the first graduate of the combined law and medicine program at the Duke University Schools of Medicine and Law. You do seem, parenthetically, to have an oversupply of Duke people here today. [Laughter.]

The statement that we present today outlines the general views of the College of Physicians on the need to raise the appropriate kinds of questions about medical professional liability and about defensive medicine and on the need for improved information on which clinical decisions can be based. The context in which we discuss today's medical professional liability is, as you've already heard today, one that's all too familiar: that of health care costs. Physicians are concerned about the almost-geometric increases in the medical professional liability insurance premiums, and physicians, the public, and Congress are concerned that the threat of malpractice litigation may lead to the performance of costly but medically-unnecessary procedures; that is, defensive medicine.

While there is general agreement as to the general definition and, at least, the occasional occurrence of defensive medicine, it has neither been well qualified nor well quantified. Everyone says it exists but few physicians would admit that they, themselves, practiced it in any specific case, and no one knows the actual incidence of the practice. Whether this lack of objective data regarding the practice is a function of the paucity of the studies that have been done, or of the near impossibility of accurately quantifying its incidence, is not known. Most general surveys of defensive medicine beginning in the early 1970's clearly indicate that physicians believe the practice of defensive medicine to be widespread and highly prevalent. The central problem with most surveys, however, from the standpoint of the validity of their quantitative data, is that they fail to take into consideration that behavior is the function of a multiplicity of factors; and while it may be true that one of the factors active in a diagnostic or therapeutic decision is fear of a malpractice suit, there are certainly many others.

The more important question to be asked of the physician is whether, in any specific case, defensive medicine plays a significant role in the medical care choice.

Defensive medicine probably does exist in general, and most certainly exists in relation to specific cases. Whether, however, solutions should be proposed that deal solely with defensive medicine should depend on solid information as to the nature and the extent of the practice. I believe it very likely that the threat of malpractice litigation is but one of several factors that influence the clinical decision. Other factors may be equally or more important, and those can be the nature of medical education, the structure of the reimbursement system as you've heard today, the growth of medical technologies, and patient expectation.

Before changes affecting one of these factors, professional liability, are instituted, it would be valuable to know how all the factors interact and how changes in one may affect the others.

A word now about the responsibility of the medical profession. The legal standard to which the physician is held is, in essence, that of other physicians in similar circumstances. This society affords the medical profession the hallmark of being a profession: the right to set the standards by which it, itself, is to be measured. We, as a profession, should take that right and that responsibility seriously and be more willing to speak to what constitutes appropriate practice.

Part of the difficulty with defensive medicine is that its practice falls in the void area between science and art. What the medical profession needs more of is information that would increase the science and decrease the uncertainty of clinical decisionmaking. The medical profession should expand its existing efforts to examine critically the diagnostic and therapeutic procedures that we use, and to develop guidelines based on the best existing data and expert opinion, on their use. The development, analysis, and dissemination of such information could aid the individual physician in not only making more medically-effective and cost-effective clinical decisions, but could also give the physician some assurance that he or she was meeting some appropriate professional standards of practice.

The medical profession should assume our professional responsibility and address what is and what is not appropriate medical care. Were we to do so, the practice of "defensive medicine" would, in fact, diminish. But in order for medicine as a profession to establish and disseminate information on what constitutes appropriate clinical practice, the development of much more information on the relative value of medical procedures is needed.

Mr. Chairman, the college is grateful for the opportunity to appear before you today, and I would be pleased to respond to any questions that you might have.

[The prepared statement of Dr. Ball follows:]

STATEMENT
OF
THE AMERICAN COLLEGE OF PHYSICIANS
BEFORE THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

July 10, 1984

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

The American College of Physicians (ACP) is pleased to have this opportunity to appear before you today to discuss some of the issues involved in medical professional liability, most particularly defensive medicine. My name is John R. Ball; I am the Associate Executive Vice President for Health and Public Policy of the ACP. I am both a physician and an attorney, and was the first graduate of the combined law and medicine program in the Schools of Medicine and Law at Duke University.

The American College of Physicians was founded in 1915 to uphold high standards in medical education, medical practice, and medical research. Today the College represents over 60,000 doctors of internal medicine, specialists in related non-surgical fields, and physicians-in-training. Approximately one-third of our members are Fellows of the College (FACP), a designation based upon their having met standards of scholarship and contribution to the science and practice of medicine beyond their eligibility for specialty board certification in internal medicine. The ACP membership includes private practitioners providing primary health care; medical specialists in such fields as gastroenterology, endocrinology, oncology, and cardiology; medical educators; and researchers. It is the largest organization of general internists and allied subspecialists in the world.

The statement presented today outlines the general views of the American College of Physicians on the need to raise appropriate questions about medical professional liability and about defensive medicine, and on the need for improved information on which more informed clinical decisions may be based. The statement also reflects my personal background in examining these issues over the last several years.

The Context of Today's Concern Over Medical Professional Liability

The context in which today we discuss medical professional liability is one that is all too familiar: that of health care costs. Physicians are concerned with the almost geometric increases in medical professional liability insurance premiums; and physicians, the public, and the Congress are concerned that the threat of malpractice litigation may lead to the performance of costly, but medically unnecessary, procedures -- defensive medicine. In this context it is useful to remember that some health policy issues are cyclical; thus, it may be instructive to examine briefly the so-called "malpractice crisis" of 1974-75 (more accurately termed a crisis in the availability of medical professional liability insurance), and to see what lessons may be drawn from it.

The many underlying factors that may have contributed to the malpractice crisis of a decade ago were, in a general sense, of two sorts: medical and legal. Since others on today's panel will no doubt comment on the legal factors involved, I should like to focus on some of the medical factors that were likely involved.

Medical factors that led to the crisis of 1974-75 were: (1) a change in the way medicine was practiced; (2) the professional response to the effects of those changes; and (3) the response of patients to those changes. Medical practice had become rapidly and increasingly sophisticated. The dramatic growth in medical technology and the more frequent use of complicated machines and procedures meant that more could be done for the patient but also that more could be done to the patient. Technology had resulted in striking gains in medical care, but it had also increased the risk of more serious adverse results. Further evidence of the sophistication of medical practice was found in the explosion in the numbers and kinds of personnel which take part in patient care. Nearly 150 different categories of health personnel are licensed or in some other way credentialed. The involvement of more people in the treatment sequence increases the risk of communication and follow up errors.

The professional response to these changes, and particularly to the risks they occasioned, was, according to the 1977 report of the American Bar Association Commission on Medical Professional Liability, not adequate. Within the medical profession, medical disciplinary procedures did not increase in sophistication with the increasing sophistication of medical practice. Physicians, once licensed, were in general able to practice for life, and in almost all states, incompetence was not grounds for lifting the license. Even where it was grounds, it was rarely used, and where used, could be fought for years in the courts. Provided with few alternative mechanisms by which to discipline, it is little wonder that licensing boards and medical societies may not have been sufficiently effective in disciplining physicians. The response of hospitals was similar. Faced with the increasing risks of patient injury within it walls, the hospital was slow to recognize its responsibility for medical malpractice. Thus, hospitals also made inadequate efforts to prevent the occurrence of adverse incidents. Like the licensing boards, hospitals had available no proven mechanisms, nor did they have sufficient incentives to do so. With developing changes in medical practice and changes in the law, those incentives have changed.

The patient response to societal change, including changes in medical practice, has been dramatic. Increasing sophistication and striking complexity of medical care has led to increased patient expectation. The fascination of people with the mechanics of technology is further reflected in their fascination of what technology can do. Patients have come to expect that complex machinery; sophisticated hospitals, and super-specialized personnel should produce improved health outcomes. When they do not, and especially when they produce an adverse result, the patient is apt to feel aggrieved. In addition to great expectations, the patient is today much more knowledgeable and much more willing to learn about health matters. The patient, no longer mystified by the mechanics of medical care or by its jargon, increasingly is ready to question the quality of care. Not only is the patient ready to question, but also is ready to ascribe the responsibility for poor outcomes to health care providers. This readiness may be to some extent attributable to unreasonable expectations as to the ability of medicine to cure; it may reflect medical specialization and the resultant depersonalization of care. Finally, it may reflect a greater litigiousness -- a greater willingness to sue -- in the population. In almost all fields a penchant for litigation is being seen. This may reflect a denial of individual responsibility for adverse events; it may indicate that people are less willing to accept the wrongs of others; or it may mean that people view the courts as the proper forum for settling more and more differences. Why people sue is not clear; that they increasingly do so is certain.

The Professional Liability System as a Quality Assurance Mechanism

The professional liability system in law may be said to serve three general functions: quality assurance, discipline, and compensation. Whether such a haphazard system can be efficient, just, or adequate in any of those capacities is questionable. Although the threat of litigation by a dissatisfied patient may influence the quality of medical care, the extent and effectiveness of this deterrence is uncertain at best. Yet consumers perceive the legal system as an important means of quality assurance because, in part, they perceive no other course available to them.

Although the legal system can serve as a quality assurance mechanism, it is grossly inefficient in this capacity because its primary mode of control is deterrence -- the threat of a lawsuit in the event of malpractice. The legal system has no procedure than can routinely identify inappropriate medical practice that could effect change. The failure to identify inappropriate patient outcomes in a systematic fashion, the absence of any procedure for changing the process to achieve better outcomes, and the lack of any process designed to evaluate the effect of the system as a whole, all argue against the complete reliance on the legal system as a mechanism of medical quality control.

For similar reasons, that is, the inability to identify in a systematic fashion inappropriate practice and incompetent practitioners, the legal system is equally deficient as a means of disciplining health care providers.

In addition, professional liability as a system of patient compensation is inefficient. Estimates of the percentage of the professional liability premium dollar that eventually reaches the injured patient range from 12% to 38%. Although such figures may be somewhat misleading because insurance serves purposes in addition to compensation of injured plaintiffs, they do symbolize the high administrative and other costs associated with the professional liability system in law, and perhaps, the need to develop other compensation schemes that may minimize these costs.

Thus, aside from its historical background, the professional liability system in law continues because there are no existing alternatives to some of its functions, although it may be inefficient, unjust, or inadequate in performing those functions.

Defensive Medicine

One of the effects of the professional liability system in law, specifically of the threat of litigation, is defensive medicine. Defensive medicine, defined as medically unjustified care provided for the purpose of reducing the possibility of a malpractice suit, is frequently alleged to represent bad medicine and to increase the cost of medical care. Defensive medicine is generally stated to be of two kinds: positive, *e.g.*, the provision of medically unnecessary services, and negative, *e.g.*, the failure to perform an otherwise beneficial procedure which carries significant risk of a bad result and which thereby is thought to be a likely cause of suit. While there is general agreement as to its definition and to at least its occasional occurrence, defensive medicine has been neither well quantified nor qualified. Everyone says it exists, but few physicians will admit they themselves practice it in any specific case, and no one knows the actual incidence of the practice. Whether this lack of objective data regarding the practice is a function of the paucity of studies that have been done or of the near impossibility of accurately quantifying its incidence is not known.

Most general surveys of defensive medicine, beginning in the early 1970's, clearly indicate that physicians believe the practice of defensive medicine to be widespread and highly prevalent. The central problem with most such surveys, from the standpoint of the validity of their quantitative data, is that they most often ask in essence the question "do you practice defensively?" The easy answer, of course, is "Yes," but such a question and response fail to take into consideration the notion that behavior is a function of a multiplicity of factors, and while it may be true that one of the factors active in a diagnostic or therapeutic decision is fear of a malpractice suit, there are clearly many others. The more important question to be asked of a physician is whether, in any specific case, defensive medicine plays a significant role in a medical care choice. In addition, it is necessary to inquire as to whether that significance can be translated into the cost of care, not only as measured in dollars, but also in factors such as physician frustration, patient injury, or a host of opportunity costs which are only partially measurable in terms of dollars. In other words, is defensive medicine bad medicine, or is what is named defensive medicine actually good medical care by another name.

The earliest study of defensive medicine, published in 1971, recognized that other factors beyond the fear of litigation are responsible for behavior or medical care choice. The basic conclusions of that study were that defensive medicine is practiced, but not to the extent alleged, and that, in fact, other factors are far more important in specific case decision-making. The study identified a wide variation in physician opinion as to the value of specific medical procedures and in their frequency of use, and further speculated that defensive medicine, when practiced, represented the physician's failure to adequately weigh the cost-benefit of a procedure. The study speculated that defensive medicine is probably more significant as an indicator of the weakness of cost constraints in the medical care system than of a dysfunction of the malpractice suit.

To resolve the questions of the extent and effect of defensive medicine, objective information is needed. Specifically, an identification of those procedures or practices in which fear of suit is a significant factor, and a quantification, to as great an extent as possible, of the cost of the practice in the specific case should be undertaken. There have been occasional such studies, the earliest in 1971. That study revealed that "routine" skull x-rays were not necessary in every case of head trauma, and that medical criteria could be constructed which could objectively inform the medical decision whether or not to take skull x-rays.

Defensive medicine probably does exist in general, and most certainly exists in relation to specific cases. Whether, however, solutions should be proposed that deal solely with defensive medicine should depend on solid information as to the nature and extent of the practice. I believe it very likely that the threat of malpractice litigation is but one of several factors that influence the individual clinical decision. Other factors that may be equally or more important are the nature of medical education, the structure of the reimbursement system, the growth of medical technologies, and patient expectation. Before changes affecting one of these factors -- professional liability -- are instituted, it would be valuable to know more about how all the factors interact, and how changes in one may affect the others.

A Responsibility of the Medical Profession

Under the present professional liability system in law, the legal standard to which a physician is held is that of other physicians in similar circumstances. Thus, society affords the medical profession the hallmark of any profession: the ability to set the standards by which it itself is to be measured. As physicians, we recognize that disease processes have generally predictable courses, and that most patients respond in generally predictable ways to diagnostic and therapeutic procedures. Equally importantly, we recognize the occasional unpredictability of diseases processes and the inherent variability of individual patient's responses. These dichotomies -- between predictability and unpredictability and between usual and variable -- are what makes medical practice both a science and an art.

Part of the difficulty with defensive medicine is that its practice falls in the broad area between science and art. What the medical profession needs more of, and where the medical profession can be of help, is information that would decrease the uncertainty of clinical decision-making. The medical profession can continue to expand its existing efforts to examine critically the diagnostic and therapeutic procedures that we use, and to develop guidelines, based on the best existing data and expert opinion, on their use. The development, analysis, and dissemination of such information, at least in specific cases, could aid the individual physician in not only making more medically effective and cost effective clinical decisions, but could also give the physician some assurance that he or she was meeting some appropriate professional standard of practice.

In order for medicine as a profession to establish and disseminate information on what constitutes appropriate clinical practice, the development of much more information on the value of medical procedures is needed.

Conclusion

This statement has sought to highlight lessons that might be drawn from the "malpractice crisis" of a decade ago. A central set of factors underlying that crisis relate to the manner in which medical practice had changed over time, to the medical profession's responses to those changes, and to the public's, or patient's, responses to those changes. In addition, I have attempted to point out certain inadequacies in the professional liability system in law as a quality assurance mechanism, and to suggest that the medical practices named "defensive medicine" are likely determined by a variety of factors, not only by the fear of litigation. Finally, I have suggested that one way in which the practices that may fall under the name "defensive medicine" may be made more appropriate is for the medical profession to enhance its activities in evaluating the medical value of diagnostic and therapeutic procedures, and to establish guidelines for their appropriate use.

Thank you for the opportunity to appear before you today. I would be pleased to respond to any questions you may have.

Senator **Quayle**. Thank you.

John Hoff.

STATEMENT OF JOHN S. HOFF, LEGAL COUNSEL, NATIONAL COUNCIL OF COMMUNITY HOSPITALS

Mr. **Hoff**. Thank you, Senator Quayle.

I appear here on behalf of the National Council of Community Hospitals.

There is no question that the present malpractice system, particularly as it affects medical malpractice, is unacceptable. We can leave aside the question of whether or not we have a crisis because I think that dispute and that debate that has been going on this morning is nothing more than semantics. With the possible exception of the trial lawyers, whom you will hear from next, I believe no one appears here today as an apologist for the present system. Everyone has supported modifications, although the modifications may be different and the intensity of the feeling behind those modifications may vary.

The witnesses have all presented to you slightly different numbers on the extent of the problem. But they have all, by doing so, staked out the parameters of what is clearly a problem. And the basic facts are clear; the present system pays most victims of malpractice nothing. It pays a very few fortunate victims very large recoveries, recoveries based on emotion and subjective awards having nothing to do with their real economic loss. The system is clearly slow; even those who win must fight an average 5 to 7 years of litigation to win those big judgments. The system is expensive; it consumes vast amounts of resources from lawyers and expert witnesses as well as the societal and governmental costs of running a court system.

The system is traumatic for all who are involved in it. For the plaintiffs, who must endure the litigation, and for physicians, who are the targets. And the system is fortuitous; depending on the skill of the lawyer, the nature of the jury, the location of the court, and the emotional appeal of the plaintiff, different plaintiffs will receive different awards for the same injury.

And, although it can't be quantified, it clearly contributes to "defensive medicine." Physicians react to large, well-publicized verdicts, and it is the large verdicts which are well publicized.

What is needed is not a recitation of the problem but an investigation into possible reforms; and, Senator Quayle, you are attempting to do that here this morning. We urge you, as part of your consideration, to consider S. 2690. This bill makes a few modifications in the current tort system. It is intended to provide a mechanism for more patients to receive payment for any economic loss that they suffer. It rechannels money now spent on litigation costs and paying a few people for noneconomic loss, to people who now collect nothing. The bill would do this by encouraging providers to pay victims for their economic loss. If the provider makes a commitment to make such payment as it accrues over time, the provider cannot be held liable for noneconomic loss. Providers, therefore, will be encouraged to make this commitment to pay victims and money now spent on transaction costs will be saved and more money will be available for plaintiffs.

The bill also prevents plaintiffs from recovering twice, as is possible under the present system. As other witnesses have testified, by introducing a collateral source rule and netting off collateral source payments from the amount that would otherwise be due the plaintiff, the bill would do this.

It must be emphasized that the proposal embodied in the bill is not a no-fault plan. The proposal is still based on fault. The provider does not have to make a tender to pay damages and would not make a tender where he believes that he was not liable. It will, therefore, not cost more than the present system; in fact, it will cost less as transaction costs are avoided and large noneconomic damages are avoided.

The bill does not propose, and the system should not, pay for all injuries. That would, as Professor Danzon has said, constitute a grossly expensive national insurance program. I emphasize that the bill would not have that effect.

Finally, I would also urge, in response to some other statements, that economic loss cannot be paid by schedule; it must be done by individualization. If Jascha Heifitz loses two fingers, he should be compensated more, Senator, than you or I.

[The prepared statement of Mr. Hoff follows:]

NCCH
NATIONAL COUNCIL OF
COMMUNITY HOSPITALS

STATEMENT OF
NATIONAL COUNCIL OF COMMUNITY HOSPITALS

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

July 10, 1984

My name is John Hoff. I am a lawyer, practicing in Washington, D.C. I appear today on behalf of the National Council of Community Hospitals, an organization of approximately 110 community hospitals in 32 states around the country, which provide approximately 50,000 beds. NCCH and its members are committed to the formulation and support of reforms in the health care delivery system.

This Committee's interest in defensive medicine and medical malpractice more generally is appropriate, and timely. A renewed malpractice insurance crisis may be impending. But in addition to any particular crisis, chronic and continuing problems are posed by the present malpractice system.

Compensation for patients who suffer from malpractice is of great concern to hospitals. They are concerned both because of their dedication to the well-being of their patients and because of the increasing costs they incur when untoward events occur in a hospital. A generation ago hospitals were immune from tort suits under the doctrine of charitable immunity. With that doctrine effectively eliminated, hospitals pay for tort recoveries and malpractice insurance. Premiums for malpractice insurance have continually increased. There was a malpractice crisis in the mid-1970s during which premiums increased rapidly and insurance was difficult to obtain. After a short-lived dip, malpractice premiums have continued to increase since then, and there are indications that a new malpractice crisis is now brewing.

The malpractice insurance crisis cannot be addressed in isolation. It is a consequence of the tort system by which we determine who will be compensated for what injuries, and how much they will receive.

The present tort system is a cumbersome, expensive, and inefficient method of determining compensation. The system promises large and even windfall gains for a few victims totally without regard to what they need for compensation, but denies fair payment for most victims.

Recovery is allowed not only to compensate the injured patient for his real economic loss but also to pay him for his "pain and suffering," and various other theories of noneconomic loss, and to extract punitive damages from the defendant. These elements of damages are entirely subjective, and the amount of verdicts awarded are matters largely within the discretion of the jury. The emotional appeal of the plaintiff to the jury is a critical element in determining which patients recover, and how much they can recover.

In addition, plaintiffs can in some instances collect twice for the same damage -- from the tortfeasor and from collateral sources.

Recovery depends upon proof of negligence -- a concept difficult to establish in as inexact an activity as medical care. Juries do not have personal experience in diagnosing disease or performing surgery. The reasonable man, therefore, must be guided by expert witnesses. The result is trial by phalanxes of experts who evaluate a physician's decisions with the wisdom provided by hindsight.

The system holds out the promise of very large recoveries, far in excess of real economic loss. Plaintiffs are encouraged to go for the big win. But very few actually collect on the promise. Those who do typically must litigate for five to seven years before they prevail, a process which not only delays receipt of compensation but is often traumatic to the patient who must undergo it. And the litigation process is expensive -- to plaintiffs, defendants, and to society as a whole.

The tort system is not only a flawed way of paying patients who are the victims of malpractice. It also has adverse effects on the health care system. Most importantly, the fear of large recoveries and attendant publicity forces physicians to engage in defensive medicine, which the American Medical Association estimates costs $15 billion a year in added physician costs alone, as well as subjecting patients to added risks and inconvenience. The fear of malpractice forces physicians to abandon high-risk areas of practice. And the cost of malpractice premiums leads to increases in physician fees.

The risk of a physician being sued is increasing rapidly. Recent data collected by the AMA, for instance, reveal that the percentage of physicians against whom a claim is brought in a year almost tripled in the period 1978-83: from 3.3 to 8.0 per 100 physicians. When a physician, despite doing what he believes is his best on behalf of his patient, is sued, it often has a traumatizing and debilitating effect on him.

The Committee will hear ample and detailed criticism of the present system for paying patients for medical malpractice, and the relationship between that system and the practice of defensive medicine. What is most needed are ideas for reform.

NCCH, therefore, wishes to urge the Committee to give serious consideration to S.2690, the Alternative Medical Liability Act. This proposal would make several modifications in the present system to provide a fairer and more effective system for paying patients. The bill would use money now spent in transaction costs and in paying noneconomic recoveries to a few patients to provide fair payment of economic losses to more patients, and do so quickly and without the expense and trauma of litigation. It is fairer both to patients and to providers, and to society generally.

The bill encourages providers to make a commitment to pay patients who are the victims of malpractice the real economic loss suffered by them. If the provider wishes not to be subjected to claims for pain and suffering and punitive damages, it must make a commitment within six months of any malpractice to pay the victim's real economic loss. The payments must be made for the patient's losses as they accrue -- for items such as continued medical and hospital care, wage loss, counseling, and adapting his home and car. If the provider does not make such a commitment, it may be sued for noneconomic damages, as well as economic loss, under the current system.

The bill provides incentives for providers to unearth any malpractice and to inform patients of it, since they must make a commitment to pay economic loss within 180 days of the act which could give rise to a claim if they wish to avoid liability for noneconomic damages.

The bill makes it unnecessary for patients to determine which of various participants in their care is responsible for a bad result. It relieves the patient of that dispute and forces the various providers to resolve the issue of liability among themselves.

The patient thus receives the assurance of fair payment that will make him economically whole, of receiving that payment quickly, and of avoiding the time, trauma, and risk of litigation. Money now spent to pay noneconomic damages to a few will be used to provide economic recovery for more patients. By providing the means to avoid the spectacular verdict, the bill will tend to reduce the amount of defensive medicine which is practiced, resulting in lower health care costs and improved quality of care.

These benefits will be particularly attractive to the elderly, who are concerned more about recovering their health and adapting to any infirmity than they are in pursuing for many years a lawsuit against their doctor in the hope they may eventually win a judgment which includes elements on noneconomic damages.

Most importantly, while the bill provides for quicker recovery, it is not a no-fault system. It maintains fault as a critical element in determining recovery. It does not require providers to make the commitment to pay economic loss whenever there is an untoward event but only when they believe that the unsatisfactory result of health care was the result of negligence. Because of the inevitability of death and disease, and because of the difficulties in determining causation in health care, it would be inappropriate and vastly expensive to require payment in all cases where the result of health care was unsatisfactory. The bill properly avoids that.

S.2690 sets out an idea for consideration by the States, but does not require them to enact it, and does not impose any penalty if they do not do so. However, if a State chooses not to institute a program along the lines of S.2690, the reforms made by the bill would be effective on January 1, 1987, for the beneficiaries of the various health programs to which the federal government provides financial assistance. The federal government has an interest in providing a fairer, more effective, and more efficient system for having beneficiaries of its programs compensated for any malpractice they may suffer. This is particularly so to the extent that doing so reduces defensive medicine and thus constrains health care costs. The bill correctly threads the line between States' interests and the federal government's concern for its own health programs. Beyond that, Congressional consideration of the ideas incorporated in S.2690 and other reform proposals, and hearings such as this, will encourage States to consider similar reforms of their tort systems.

Senator QUAYLE. Thank you very much.

I want to try to get a handle on the definition of how much "defensive medicine" is really going on.

Dr. Davis, you talked a little bit about "defensive medicine" and the definition of it. Are you telling us that doctors and physicians are using medical procedures or testing or evaluation, et cetera, solely because of the potential threat of malpractice suits? Are you telling us they are doing this just for that reason and there is no medical benefit from these things that may be going on and have a price tag of about $15 billion that the AMA has talked about?

Dr. DAVIS. No, sir. I am telling you that in my opinion this is only one factor of why doctors practice so-called defensive medicine. Easily, with our technological advances, much more is available to the physician so that before making a definitive diagnosis, he is asked, both in the interests of performing the very best medicine possible, to making sure that his patient gets advantage of every aspect of current knowledge, to do tests. In addition, the fear of litigation does override some of these; but I think the fear of ~~being sued~~ is only one small part of it. If one looks at the studies that have been done on what really constitutes a definition of "defensive medicine," there are many very positive aspects of it. It has been shown that physicians in this climate of "defensive medicine," if you will, actually spend more time with their patients than they did previously. They tend to maintain better records than they did previously. They are apt not to enter fields of care in which they may not be as competent as they should be. They're more apt to refer patients to other, more competent physicians.

So when one talks about "defensive medicine," I think you should remember that it does have a down side, but it also has a very positive up side. There are many benefits to society from what we are now defining as "defensive medicine."

Senator **Quayle**. So what would be the net effect, then, of the so-called defensive medicine? Is it a good thing?

Dr. **Davis**. Well, it is both good and bad, sir, if you will.

Senator **Quayle**. Well, what if we wouldn't have any malpractice system as such? Just take that as an abstract, hypothetical situation. Would we still have the so-called defensive medicine?

Dr. **Davis**. I think you would have less of it; yes, sir. I think the standards of care would still insist—and the individual's conscience would insist—that he do the very best job possible. But he may, if he has a satisfactory diagnosis, he may not get supernumerary tests to confirm that if the fear of medical liability suits is not present.

Senator **Quayle**. Would we have a lower standard of medical care if we didn't have malpractice suits?

Dr. **Davis**. I think you would have perhaps a different standard rather than a lower standard of care, sir.

Senator **Quayle**. Mr. Raines, do you want to tell us what defensive medicine is and how much of it is really going on because of the potential threat of malpractice suits?

Mr. **Raines**. Well, I think if you were to look at the way physicians practice and try to find those instances where they do something purely, exclusively out of considerations of liability exposure, they would be fairly rare. But I think that in many instances—our survey suggested that in somewhere around 75 percent more cases than in the past, the physicians considered liability as a motivating factor in determining how they would practice. These considerations, I believe, are marginal in terms of their reasonability as far as the practice of medicine is concerned; they are not cost-effective, and we have come a long way in improving physicians' cost-consciousness and elevating their concern about how much health care was costing their patients when this second manifestation of the malpractice problem, or crisis, or whatever hit us in the early 1980's. So it is affecting the choices that they make. A few years ago, if you had a discussion with a group of physicians about the appropriate management of a case, you would not hear, predominant among their considerations, exposure to liability. Today, one of the first considerations among these groups in deciding what they are going to do is, "Well, will we get sued?" Then, "What is good medicine?" And what I keep trying to advocate with our own members and with anyone I speak to about this is, let's go back to the proper way of looking at things; put good medicine first, and liability considerations somewhere down the line where they belong. But right now, the liability exposure is—certainly, at least with obstetricians and gynecologists—one of the absolute first considerations in determining whether or not to do the next test, to do the next laboratory procedure or whatever.

Senator **Quayle**. It is a consideration, but you said it would not be the sole consideration? In other words, they wouldn't be doing it solely for insulation against potential liability?

Mr. **Raines**. Probably not, because I think that even they would argue that a single test or some kind of procedure like that is not going to protect them. There's no absolute shield for liability.

They're just hedging their bets; with a good physical and a good history and that sort of thing, they can be about 95 percent sure of their diagnosis, or some substantial percentage. After that, as they conduct tests, they're simply shaving off risk factors. At some point, how much can we afford in terms of shaving off the risk factor of missing the diagnosis or not being certain?

Senator QUAYLE. Mr. Ball? Do you want to illuminate us on "defensive medicine?"

Dr. BALL. Well, one of the primary thrusts of my testimony, as well as what I can summarize of what the other panelists have said, is that it is indeed one factor. But to what extent it's important, we simply don't know. In any kind of poll or survey technique, it matters how you ask the question. If one asks physicians, "Is 'defensive medicine' or the fear of litigation one factor in your clinical decisionmaking?", I have no doubt that almost all physicians would say that yes, in certain cases, it's one factor in clinical decisionmaking. Whether it's the factor that makes the difference isn't known. I think probably in obstetrics and gynecology, there may be some data that do say that some people are dropping out of obstetrics because of the threat of litigation as the primary, if not the only, reason for it. And there are those data that do suggest that in certain specific cases, "defensive medicine" is the determining factor.

But with regard to most of the other decisions, individual clinical decisions that physicians make, "defensive medicine" is but one of those factors. To put a dollar value on it, then, is very, very difficult to do.

Senator QUAYLE. Mr. Hoff, how would you describe the driving reason and rationale for having changes in the present medical malpractice system? What is the most important factor that drives the necessity of reform?

Mr. HOFF. I can't testify to the extent to which "defensive medicine" is a driving factor because that's within the physicians' purview.

Senator QUAYLE. You would not view "defensive medicine" as the driving rationale?

Mr. HOFF. Not as the driving——

Senator QUAYLE. What is the driving rationale?

Mr. HOFF. The driving force is a feeling that the system is tremendously expensive and slow and churns and churns for a very small net recovery. That is not the best way to pay people who are the victims of malpractice.

Senator QUAYLE. Now, expensive—can we relate this to past percentages of our health care bill? Is it that much more today that we're paying out in medical malpractice than 20 years ago?

Mr. HOFF. It's not the premiums. I go back to the percentage of the premium which is recovered by the plaintiffs. I don't know what percentage that is of the medical bill, but the numbers have been given to you all morning. Whether it's 20 percent or 30 percent or 38 percent, I think that was one of the numbers, it's that part of the premium dollar that is returned to the plaintiff. This means that 70 percent or 80 percent is going elsewhere, which is not the purpose of malpractice system.

There is one study by Professor O'Connell which came to the conclusion, I believe, that 28 percent went to the plaintiff, or 25 percent, and only 12 percent went to the plaintiff for damages the plaintiff wasn't compensated for elsewhere, for example, by collateral sources. So if you assume that the collateral sources have themselves been paid for in other premiums or other methods, for the premium dollar only 12 percent, approximately, is going to the plaintiff. That means that 88 percent is going elsewhere.

Senator QUAYLE. Would that be the driving rationale for reform, to get a redistribution of the premium?

Mr. HOFF. Well, I think that the redistribution of the premium is a way of redistributing the dollars, and hopefully fewer dollars, that are going into the system, and to provide more payments—provide payment for people who are now getting nothing by using the money that's being thus wasted.

Mr. RAINES. From our point of view, one of the major concerns—probably the largest concern that we have is that it is ruining the physician-patient relationship. Every time the patient walks through the door the physician is beginning to see the apparition of the attorney behind him. And certainly things have changed in the last 10 or 20 or 30 years; between 1935 and 1975, in that 40-year period, 80 percent of the lawsuits in medical malpractice cases happened in the last 5 years of that 40-year period. The rates that people are paying for insurance have skyrocketed as a result, and the average indemnity has skyrocketed. In 1978 there were four $1 million verdicts in medical malpractice; there were something like 45 in 1983. People are getting used to handing out $1 million for medical malpractice cases. That's fine if there is some sort of public accountability for that, if we all get together and say yes, we want to make people whole again, we want to make everything right for them, and we're all willing to pay the price for it; but it appears that so far what has happened is that we have said, in our jury system, "Yes, we want to make them whole, we want to make everything right again; let him pay for it," and point to the physician and point to the insurance company. And that sort of deferred responsibility or accountability for what is perhaps a social valuation is not correct.

Senator QUAYLE. So you would be saying that the major reason or the driving rationale would be because of the deterioration of the relationship between the physician and the patient?

Mr. RAINES. That would be one thing. The physicians are concerned——

Senator QUAYLE. What motivates these reforms?

Mr. RAINES. Well, it's no fun anymore to be a physician, especially if you're in obstetrics and gynecology.

Mr. HOFF. I think you've heard testimony also, sir, this morning that the problem is a multiheaded Hydra. There are a lot of problems with the current system, and I think each of us, like the elephant, is picking out a particular piece of it.

Senator QUAYLE. Mr. Ball?

Dr. BALL. I think one of the motivations is, as you've heard—and from both of the two previous panels, as well as Mr. Hoff—is that the tort system is both inefficient and ineffective in both of the reasons for medical malpractice; that is, both in compensation and in quality assurance. I agree with the rest of the panelists that it's inefficient in the compensation system; that is, the amount of premium dollar going to the patient.

But I disagree with the first panel in that I would say that it's inefficient and ineffective as a quality assurance mechanism for a couple of reasons. One is that the system has no structured way, uniformly, to identify patient injuries. Patient injuries are identified by serendipity. The patient has to identify it, has to find an attorney to bring the case and sue for it. So there's no uniform way in which the tort system acts as a quality assurance mechanism in medicine.

Second, there's no uniform way to identify the poor practitioner through the tort system. Most physicians would say—and I think that the data bear it out—that malpractice suits fall on the good physician and the bad alike, with no real falling upon the poor physician. So the tort system has no good way of identifying uniformly the poor physician; so in that sense, the system itself is ineffective as a quality assurance mechanism.

In addition, I would think that if you look at the number of cases that have been brought against physicians and see if the standard of care has been changed because of any of those cases, I think that the data would say that no single standard of care has been changed by any one or set of cases brought against physicians. So again, if one evaluates the system, one doesn't see that it's a good quality assurance mechanism. And in part, that may be one of the driving reasons behind system reform.

Dr. Davis. Mr. Chairman, I would add to what has been said previously. There is still another desire, and that is to change the perception of what malpractice really is, of people getting rewards—and sometimes huge rewards—in which no malpractice has really occurred. Actually, well-qualified physicians—taking board certification as an evidence of qualification—are sued more often than nonboard certified because they are dealing with the more intricate procedures requiring use of modern technology.

And so we would like to see the whole perception of this change with emphasis on the practice of medicine. As rapidly as medicine is moving forward, it is still an inexact science. It cannot give computer results. A lot of subjective judgment on the part of the practitioner has to go into this decision, and so we would like to see the whole perception of this changed due to the fact that where true injury has been done, that patient be compensated and compensated early and adequately; but where there is just less than a total perfect result, less than the patient expects, does not constitute malpractice.

Senator Quayle. In other words, you're saying you would like to get away from the jury system?

Dr. Davis. Well, yes, that might be one aspect of it; or have a jury instructed as to what they should consider. It's my personal feeling the jury sometimes has the belief that if less than a perfect result has been obtained, that patient is due compensation. We don't think this is malpractice.

Senator Quayle. I don't know if those are the judge's instructions. At least, they should be; I think there is a degree of reasonableness and unreasonableness but I know what you're saying, you really want to substitute a different process than the jury determination because you don't necessarily go along with some of the decisions and findings of malpractice that would gather.

Dr. DAVIS. Yes.

Senator QUAYLE. OK. Thank you all, very much.

The final panel is Thomas Bendorf, David Shrager, Alvin Bakst and Isaac Sultan.

Mr. Bendorf?

STATEMENT OF THOMAS BENDORF, EXECUTIVE DIRECTOR, ASSOCIATION OF TRIAL LAWYERS OF AMERICA

Mr. BENDORF. Mr. Chairman, my name is Tom Bendorf. I'm an attorney from Columbia, SC, and I represent the Association of Trial Lawyers of America, and I think my principal claim to fame is that I've become something of a "numbers cruncher." In the last 13 years I've finally found where most of the figures are buried and I'm able to usually bring them to light, and sometimes even explain some of them.

I've been interested, listening today, to a number of suggestions that there's something wrong with malpractice insurance because it only provides perhaps 20 or 30 or 40 percent to the victim. All insurance only provides 30 or 40 percent to the victim. All casualty insurance only pays about 50 cents on the dollar in claims. If the studies that indicate that approximately 25 percent of the dollars paid to victims go to plaintiffs' attorneys whom they have had to hire to get the money, then presumably 37½ cents is a pretty good average. Actually, the malpractice figures don't bear that out simply because they're not old enough. There has only been malpractice information since 1975; in 1975, the National Insurance Commissioners broke out medical malpractice as a separate line, so the information that's available, that we have, is 8 years old.

Some interesting little aspects of that information are that the insurance industry—the entirety of the medical malpractice insurance industry has made more in investment income on loss reserve for medical malpractice than they have paid in claims. St. Paul is an interesting company in one respect; they're the largest commercial carrier; MLMIC, Medical Liability Mutual Insurance Co. of New York, is a doctors' company, and it's the largest noncommercial underwriter. Their figures are almost exactly the opposite in some respects. St. Paul has reduced its estimates of incurrence, which is what they said they were going to pay out, more in the 8 years that we have available to us than they have paid in claims. They have also obviously earned more investment income than they have paid in claims.

I thought I'd read a couple of figures. I also apologize for some of the materials that I presented to you; that's almost only a synopsis. The next time I'll bring them in boxes for you.

Senator QUAYLE. We prefer the synopsis. [Laughter.]

Mr. BENDORF. They make great winter reading, and I presume you're going to be spending a number of winters on this subject.

Senator QUAYLE. Go ahead.

Mr. BENDORF. The companies identified by A.M. Best as writing 95 percent of the medical malpractice insurance in the United

States of America have the following net earned premiums for the preceding 6 years: 1977, $1,131 million; 1978, $1,162 million; 1979, $1,165 million; 1980, $1,193 million; 1981, $1,229 million; 1982, $1,294 million. If that is accurate you can divide those figures by 0.95 and determine what the total net earned premium was for medical malpractice from 1977 to 1982 I've provided you a lot of figures that are available for 8 years, but unfortunately the same companies aren't reported.

The medical malpractice insurance premiums, which are apparently in the neighborhood of $1.5 billion—and I say apparently because the new figures have not yet been published; they'll be published in a month or so—represent about one-third of 1 percent of what is the estimated cost of the delivery of health care in the United States of America, about one-third of 1 percent. The claims paid to victims probably represent about $2 for every man, woman, and child in the United States, while the cost of the medical care system is about $1,425 for every man, woman, and child in the United States. That assumes that the $325 billion figure has some validity; I can't define or demonstrate that.

The subject of medical malpractice insurance is finite, it's clear, there are records—there is probably some expense to getting the totality of the records—but you can know, without the necessity of any hyperbole, without any rhetoric, you can know exactly what you want to know about medical malpractice insurance because it is all filed, it's all available in the State Insurance Commission's offices; and I hope that in the ensuing years and journeys through this wonderland that a lot of that information will become available to you and that you'll look elsewhere for problems connected with medical malpractice.

Thank you.

[The prepared statement of Mr. Bendorf follows:]

STATEMENT OF THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA ON THE SUBJECT OF MEDICAL MALPRACTICE

BEFORE THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
98th CONGRESS, 2nd SESSION

July 10, 1984

We are delighted to respond to an invitation which is based upon an intention to promote discussion on the issue of medical malpractice and medical malpractice insurance.

My name is Tom Bendorf, I am an attorney from Columbia, S.C., and I am here representing The Association of Trial Lawyers of America.

We have noted that the Committee has structured this inquiry as an oversight hearing. We believe you will have the opportunity to distinguish the true facts from the incredible hyperbole which has preceded most discussions on the subject. We are prepared, as always, to support your efforts in the search for truth.

Everyone knows that insurance simply is a risk pooling mechanism. That is any number of individuals who suffer some risk of loss can, by pooling their risk, reduce the potential impact on any one of them and bring the total loss into a manageable amount. That was true when merchant fleets began pooling their losses over two thousand years ago, it is true today when professionals, be they doctors, lawyers, architects, or whomever, pool their risk under some sort of insurance mechanism.

Now, what happens when the insurance company receives a dollar in premium from the individual who wishes to shift his risk to the insurance mechanism? The insurance company receives the dollar, they apply a certain amount of it to their expenses, acquisition expenses, operating expenses, etc., and they apply a certain amount of it to what is known as "incurred loss." "Incurred loss" is a figure that really comes into play at the end of the year when they file their annual report. At the end of their year when they file their tax return they will have determined what their incurred losses will be for the year's premiums. Incurred losses consist of losses paid, change in reserves for known claims and change in reserves for claims incurred but not reported (IBNRs). They also deduct loss adjustment expenses and reserves for loss adjustment expenses. When they add their expense package and their incurred losses and incurred loss adjustment expenses and compare those to premium dollars, they have an underwriting profit or an underwriting loss. The losses paid portion of incurred losses represents those dollars paid to claimants during that calendar year for occurrences of all prior years and for occurrences of the current year. The reserves for incurred losses and incurred loss adjustment expense will be used to pay in future years any claims that arise as a result of occurrences this year. Now these facts remain the same whether we are talking about occurrence policies or claims made policies.

Medical malpractice, legal malpractice, architects malpractice, or errors and omissions insurance or professional responsibility insurance have what has become known as a long tail. They spell it t-a-i-l, we spell it t-a-l-e. This can be a long tail, because the statute of limitations ordinarily runs from the time the person is injured, or knows that he is injured or should have known that he is injured. In the case of medical malpractice or legal malpractice a substantial amount of time can pass after the occurrence itself. For example, a child is brain damaged at birth through the negligence of an anestheologist or the negligence of an obstetrician. That child's statute of limitation may be tolled, it generally does not begin to run until the child is twenty-one. Many states have reduced that age, but the same theory that does not allow a minor to contract should not allow a minor to give up his rights until he has reached his majority. And this long tail, the high reserving that is required to overcome inflationary forces, produces curiously and concomitantly a tremendous amount of investment income for the insurance company. The insurer is required by the regulator, the state insurance commissioner, to maintain a certain level of loss reserves. And because he has these reserves for decades, literally, he may make a fantastic amount of investment income by investing those assets which are in effect frozen by the requirement of the commissioner that the insurer maintain a certain level of reserves. The insurance companies like to say that reserves are liabilities and that liabilities do not earn income. That is true. There is an asset, however, which is out at investment, which asset is encumbered by the liability. And thus, the insurance company is making incredible profit while they are holding those assets for ultimate payment to claimants. This is not necessarily true in other kinds of insurance. Workmen's compensation insurance does not have a long tail. Auto liability insurance does not have a long tail. Home owners has virtually no tail at all.

Product liability does not have a long tail, but all types of professional liability may remain a risk for literally generations. Let us take a look at the universe, as best we can understand it, of medical malpractice insurance.

Medical malpractice has been reported as a separate line since 1975. In eight years from 1975 through 1982, the leading insurers took in ten billion sixty two million in earned premiums. During that same period they paid claims of two billon two hundred and five million. They currently have reserves in excess of seven billion dollars nine hundred seventy-eight million and their investment income, an estimate based on a 10% rate of return for 1975 - 1982, is approximately two billion seven hundred fifty-five million dollars. In other words, they have made more in investment income on medical malpractice reserves than they have paid out in claims. The average claims paid per doctor in the United States seems to be somewhere in the neighborhood of $2,300 a year. And the base of this kind of information: what is the justification for $5,000, $10,000, $20,000, $35,000, a year premiums being charged certain physicians and surgeons in this country today? The real answer, of course, is that there is no justification.

In truth, the doctors have, over a large part of this country, learned this and have undertaken to pool their own risk without going to the commercial carriers. These are known in the trade by a euphemism, they are called "bedpan mutuals." Doctors, hospitals, health care providers, have undertaken to insure themselves and have met with great success throughout the country. Currently the harbingers of doom and gloom and the commercial insurance industry have pointed to impending disaster for these so-called "captives", for the bedpan mutuals. And to an extent, because the bedpan mutuals are regulated by the same insurance commissioners, and because they have to maintain the same level of reserves in spite of the fact that investment income would seem to produce dollars at a greater rate than claims produce negative dollars, the history shows that the bedpans are alive and well and probably represent the wave of the future in professional liability insurance.

Perhaps the harbingers of doom for the doctors mutuals would explain, or can explain, why St. Paul by December 31, 1982 had reduced its estimate of incurreds for 1975 by $10.720 million and for 1976 by $39.015 million, effectively transferring, therefore, from their estimate of incurred losses and their loss reserves, to surplus, $49.735 million for those two years alone. Or, perhaps they can explain why Aetna by 1982 had reduced its estimate of incurreds for 1975 by $2.726 million and for 1976 by $980 thousand, effectively transferring, therefore, from their estimate of incurred losses and their loss reserves, to surplus, $3.706 million for those two years alone. These are hardly manifestations of squirrels gathering nuts in preparation for a hard winter.

What lies behind all the rhetoric about medical malpractice insurance, however, is nothing more, nothing less, than medical malpractice itself, people being unnecessarily, unjustifiably, unconscionably injured and killed by the providers of medical services and care.

Everyone knows about instrument counts. Despite the perfect sense that they make, it was only after numerous successful lawsuits that they were adopted as standard operating procedure across the country. And, yet, incredible in themselves and even more so in their proximity in time, two instances of medical neglect show what the real "medical malpractice crisis" is all about.

In March of 1981, the Washington Post reported that Mrs. Elaine Mezich, of Seattle, developed a sharp, cutting pain in her abdomen and was rushed to the hospital where x-rays indicated a 6-inch pair of forceps, left there, as it turns out, five years previously during an operation. Less than a month later, the Post ran an article about a 31-year old nurses' aide who hurt her back and went in for precautionary x-rays. Her physicians told her that there was nothing wrong with her back, but that there was something else she should know. In her abdomen was -- guess what! -- a 6-inch pair of forceps, left there, it turns out, 5 1/2 years previously during an operation. (These were not the same woman).

Even more frightening was an AP report, published by the Post between the "forceps" articles, about Virginia Edmonson and Annie Robinson, who checked into a Philadelphia hospital in March. Mrs. Edmonson, who checked in with a ruptured disc, had a nodule removed from the parathyroid gland in the front of her neck, while Mrs. Robinson, who thought she was going to have her parathyroid gland removed, underwent the initial stages of a cervical laminectomy at the back of her head. The hospital admitted the error and said it was "horribly regretful." And so it goes.

It cannot be pretended that the primary cause of the problem is anything but medical malpractice. We hope that sometime it will be better recognized that the one sure way to end this debate is to eliminate wrongs, not rights.

The insurance industry has been successful in shielding its profitability and securing outrageous premium increases through clever advertising, through the print and electronic media, and by lobbying in the states for favorable legislation.

Their legislative efforts were rewarded with unprecedented activity. At no other time in the history of the United States have state legislatures moved with such unanimity or with greater rapidity than they did to confront the medical malpractice problem. Between 1974 and 1976, every state in the union passed some malpractice law, and while a number of these acts attempted to deal with only one or two specific issues, most frequently the legislation was of an omnibus nature.

Coupling their demands for confiscatory rate increases with threats that they would leave doctors uninsured, the insurers created, on their own, a potent pressure point on the legislators. Furthermore, just as consumers bought the argument that no-fault would reduce their auto insurance rates, so did the doctors believe that "tort reforms," and specifically the "tort reforms" the insurers wanted, would solve their malpractice problems.

The insurance industry undertook this effort because it is worth millions to them, the potential dividends total billions of dollars. They saw the medical profession as the prime consumer, able to pay larger premiums, and well enough organized to pressure legislators to change laws. Their plan was to eliminate the right to recover fair and full reparation for injury. The insurance industry calls it the "drive for tort reform." However true, tort reform should eliminate torts or wrongs, not remedies or rights!

The methods of persuasion are obvious to us, but unfortunately not to the consumer. The medical profession is not the only "consumer" involved. Consumers should include all those who will avail themselves of medical services and facilities. The sad fact is that these consumers seldom realize that they are the targets, or that their rights are in jeopardy until they are themselves injured.

What the consumers do perceive from the barrage of publicity is that the insurance rates are sky-high, and that it is not the insurance company's fault. The insurance industry emphasizes four main points:

1. That the court system is slow, inefficient, costly and a chancy way of getting recompense for injuries or damages.
2. That the huge verdicts by unbridled juries are driving insurance rates through the ceiling for all involved, and making some individuals uninsurable.
3. That trial lawyers, characterized as greedy and grasping, are the major culprits.
4. That the solution lies in changing the laws, state and federal, so that people will never need trial lawyers and will never need access to the courts.

The real tragedy is that this propaganda and pressure has caused legislators across the land to enact laws based on false and misleading statistics -- laws which eroded citizen's rights -- laws which responded to insurance company profit priorities and to the medical establishment's factually unfounded assertion that the only way to solve the crisis was to make it difficult for people to be made whole when wronged!

What the public and the doctors have not been told in this long tale is the real reason for "tort reform." Let us again look at the Casualty Insurance Industry. In twenty-five years prior to 1981 they suffered 13.8 billion dollars in underwriting losses! How did these losses affect them and their stockholders and their policyholders? The casualty insurance industry's assets increased in the same period -- a small increase -- from 23 billion dollars to over 197 billion dollars. These are their published figures. Do they sound like they need more help in their relentless crusade against human rights or their crusade against reparation for human wrongs?

The lack of information about the insurance process has not only caused people to make wrong decisions; it has also made them lose sight of how much or how little they actually know about the problem they are facing.

If the insurance industry is truly concerned with controlling the number of claims and accurately assessing the cost of claims paid, it should concern itself with the causes of medical malpractice. The doctors must face this problem as well.

The only cause of malpractice is negligence and as long as the medical profession is allowed to continue certain practices undeterred, the problem will grow in seriousness no matter how many bandaids are applied to this reparations process.

The answer to malpractice cannot possibly be derived from the denial to an injured person of his right to seek reparation.

Because I know the committee will wish to have access to the best information available, I have included sufficient quantities for the members and staff a detailed analysis of A.M. Best's figures complete with graphs and charts showing what happens to medical malpractice premium dollars. As you know A.M. Best is an independent reporting service which publishes financial results of the experience of the insurance industry. The figures provided are gathered from the annual statements of the companies themselves.

Thank you.

Senator **Quayle**. David Shrager.

STATEMENT OF DAVID S. SHRAGER, PRESIDENT, ASSOCIATION OF TRIAL LAWYERS OF AMERICA

Mr. **Shrager**. Hi. I'm David Shrager. I'm a practicing attorney, largely a litigator, in Philadelphia. Over about the last 25 years I've had the opportunity to screen and analyze—hopefully, sometimes thoughtfully— thousands, and litigate hundreds, of medical negligence claims. I also happen this year to be president of the Association of Trial Lawyers of America.

I hope that during the course of these hearings, Senator, you have an opportunity to use this important forum to focus, as some of the witnesses have in part this morning, on perhaps the major cost variable, and that is the underlying causes of the loss. This has to do with the threshold subject matter of what seem to be those common threads and problems which generate claims. This could be, then, a useful forum to treat what those recurring themes may be.

We heard, for example, reference earlier to some correlation thought to exist between hospitalization and cases that trigger medical negligence claims. Many thoughtful commentators seem to think there's a correlation between claims and the frequency of surgery. In this fashion, incidentally—not only these hearings—but the tort system itself has served, we think, as a tremendous crucible over the years for the accumulation of what is admittedly anecdotal data, but we now have assembled thousands and thousands of cases which could be so useful if disseminated publicly and for the benefit of the medical profession, as well.

This, then, is the potential for the salutory effect of the tort system in its conduct of what is effectively one-on-one peer review in the courtroom. Sometimes we think in lieu of that which could more rigorously occur within staff conference proceedings.

Also, I think it would be very important to hear, as I know the committee will wish to hear, from the most important and the ultimate consumer group involved: That is to say, the occasional victims of medical negligence. Incidentally, the subject matter we are discussing is really a compliment to the excellence of medical care in this country and to the integrity and good intentions and dedication and skill of the men and women who have the privilege to serve as physicians and treat patients. We are dealing with an occasional situation, the occasional patient, but these are the folks who are really on the cutting edge of what we're talking about. I hope it will be possible to chat with them and to learn what common threads, if any, there are in terms of discontent, how some of them may feel they fall through the seams in treatment; how the physician-patient relationship might better be improved. There is this whole body of health care consumers who are resident experts, and there may be much to learn.

You were interested earlier, Senator, in a couple of points to which I'd like to address myself.

First, the question of contracts and how that might somehow fit into this situation. I'm not sure it's a question so much of skepticism by the legal profession as it is in terms of certain propositions that we learned back in first year contracts. A contract, if it's worth it's salt, I expect has to be at an arm's-length basis; a handshake between two folks who understand each other and are dealing at the same level has always been, in my view, even as a trial lawyer, a more binding sort of an agreement than something that's crisp and in writing and seems to lay out the whole world between parties who may not, however, well understand each other or be in a position to interact at an arm's-length basis. I expect that most consumers would tell you, even those who presume a level of sophistication and skepticism at the medical care delivery system, that in the scenario of the physician-patient relationship or in the setting of the admissions room, there are not very many people who are other than trusting and very vulnerable. I wonder how many of us, even those who presume to be sophisticated lay persons, think very hard and critically about the consent forms that we sign. I'm not in any fashion disparaging those forms, but what I'm saying rather is that, in treating the issue, I think sensitivity needs to be paid to whether the patient is in a position to contract on matters concerning his or her health and care in addition to whether the average patient has any pretense of the expertise and knowledge that would permit that patient to knowledgably discuss the subject matter.

The final point would be with reference to "defensive medicine," and I very much enjoyed your questioning to the previous panel because what I think came out of that is that "defensive medicine," which has been used, unhappily, in a perjorative sense, may in fact be the outstanding compliment to what we all learned and, in practice, have realized since law school as the glorious aftermath of the tort system. The law does not require, as you know, "defensive" care; it requires reasonable care. And I suppose that one of the reasons that I and my colleagues are often invited, especially in the last number of years, to medical staff conferences of medical care providers and why defense counsel are increasingly invited to those conferences is to share the implications of the experience that we have learned anecdotally, to be sure, but now repeatedly over a number of years in the courtroom as to what those things are that occasion untoward negligently induced results. The importance of careful chart-keeping; indeed, when you asked one of the previous speakers as to what the implications were, I heard one of the physicians indicate "more monitoring, more testing." Fine. If so, it may be a badge of honor for our system; for after all, the challenge to medicine, as our good colleagues in medical practice will assure us, is not so much to discern that someone is well, but to identify the occasional person who is sick and to treat that individual. That, it would seem, would be the real challenge for that great profession.

So we think that "defensive medicine" in the perjorative sense has never been documented, but that in the best sense it relates to good quality medicine, the kind of medicine that we think is practiced by the overwhelming number of men and women in the medical profession.

Thank you.

[The prepared statement of Mr. Shrager follows:]

STATEMENT OF DAVID S. SHRAGER TO THE UNITED STATES SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES - TUESDAY, JULY 10, 1984.

My name is David S. Shrager. I have been a practicing attorney for approximately 25 years in Philadelphia, Pennsylvania. Much of my practice involves negligence claims on behalf of health care consumers.

It is a compliment to the Senate, acting through this distinguished Committee that a study has been undertaken of the subject matter of defensive medicine and its relationship, if any, to medical malpractice. The issue is one that has attracted substantial partisan rhetoric but, unfortunately, little thoughtful analysis from critics in the private and public sectors. If the subject is to be intelligently understood, those groups most immediately interested in the private sector, the insurance companies, health care providers, and attorneys need to lay aside their personal biases and interests and focus on the impact of any proposed changes of our system on the millions of our citizens who are health care consumers and how their rights would be affected within the framework of the American system of justice.

The dimension of this issue and its special impact upon consumer rights should be well understood. Our citizens elect their local and national legislative representatives. They can cast their votes as a function of public positions taken by candidates on important issues. They do not, however, elect or control hospital administrators or members of hospital staffs. They do not control or even have much knowledge in matters of professional training, licensure, treatment modalities, medical devices, new drugs, prescriptions, diagnostic techniques or the like. They are not at arm's length in their everyday dealing with medical care providers. They are, in fact, vulnerable and, for the most part, they are trusting and respectful of men and women who, by virtue of professional training and expertise enjoy the privilege of examining the healthy and ministering to the ill. In a word, they are not and realistically cannot be involved in peer review within the framework of the medical care delivery system.

Happily, most of our citizens as health care consumers have never needed to concern themselves in a personal sense with the quality of medical care providers, or the standards of medical practice. It is a testament to the high standards of American medicine that relatively few consumers will be subjected to incompetence, neglect or inadvertence in their medical treatment and care. Yet we know, without in any fashion disparaging the general high quality of medical care and the fine intentions and character of medical care providers, that mistakes will happen; that the wrong medication will be given; that medical protocols will not be followed; that the patient may be left unattended; that diagnoses may be missed. These are the victims of professional negligence. These patients are at the core of the consumer group whose rights are in question in this subject matter.

Fortunately, there are institutions and principles long associated with the American justice delivery system which offer decent, humane and fair treatment for these occasional victim of negligence by health care providers. Our system of justice depends on the following propositions:

1. When an individual is the innocent victim of the negligence of another, the injured party is entitled in the civil courts to seek fair compensation for the manner in which an injury has compromised his wallet and his lifestyle. It is the law's humane effort not to punish the negligent party or revoke his license to practice medicine, but to attempt as best the law can, to make the victim whole.

2. Before a party may be asked to respond in compensatory damages for injury negligently inflicted upon another, there must be a determination of fault. Responsibility does not attach merely to an unfortunate or an adverse result. Rather, there must be a determination by an impartial dispute resolution mechanism of whether or not there has been fault or negligence; otherwise, the injured patient is not and should not be entitled to be compensated through the private sector.

3. No individual or group of individuals in our society is entitled to special privilege or immunity in terms of the law's evenhanded application of the principle of responsibility for negligently inflicted injury or loss. Physicians and attorneys, for example, are held to the same standard of reasonable care as are motorists, landowners, and others whose activities may adversely impact through negligent conduct upon the interests of others. There are no elitists under the law in terms of the implications of the benchmark of reasonable care.

4. Because the average citizen, when serving as a juror, is not thought capable of evaluating reasonable standards of medical practice, the concept of "reasonable care" as it applies to a medical care provider almost always requires expert testimony so that a court and jury may be advised as to what is the applicable standard of care in terms of the conduct in question, whether there has been a deviation from that standard and, if so, the extent to which such a deviation has eventuated in injury.

5. The dispute resolution mechanism for claims alleging negligence against health care providers is what we call the adversary system in which the health care provider and the consumer are entitled to place their claims before a court and jury with appropriate expert testimony and explanations on both sides, the matter then being resolved by a verdict. In this fashion, we assume

under our democratic system that legal standards of conduct may be fairly and impartially enforced between and among individuals.

There are those who would wish to compromise the rights of victims of medical negligence by changing longstanding rules of law which have applied to the conduct of all of us, by limiting fair compensation of victims of medical negligence and by compromising our dispute resolution mechanisms, principally trial by jury. Special rules of privilege and limitations on victim rights are sought. The critics are often, in their heart of hearts, attacking not simply the institution of our American system of justice, but really the collective wisdom of our citizens who serve as jurors in the courts of our country.

The attacks from certain quarters are so extreme that one would think that the problems, such as they are, may have been generated by the patients or even their lawyers. But the problem of negligent operation of a motor vehicle is negligence by the operator of the motor vehicle. The problem of negligent medical treatment is definitionally the problem of negligence by medical treatment providers.

Medical critics of the system invoke in a perjorative sense the clever tag line of "defensive medicine" which, if taken literally, proves the point as to the salutory effect which malpractice law has in deterring and discouraging negligent practice. Thus, if "defensive medicine" implies that a physician, for example, should do something in terms of his treatment of a patient which he would not otherwise have done, solely as a function of avoiding a successful malpractice action, then the phrase is clearly a misnomer and, more than that, represents a serious offense to the great majority of medical care providers who practice good medicine and are not held responsible in negligence claims.

In the review of literally thousands of potential medical negligence claims over the years, I have never seen a single example of a case which was litigated to a verdict in favor of a patient in which there had not been a showing that compliance with reasonable standards of medical practice would not have avoided the adverse medical outcome. Good quality medical practice is the best insurance against malpractice claims. "Defensive medicine" should not be used as code words to deny or limit health care consumer rights. There is no doctrine of law in any jurisdiction in the United States which imposes an obligation on a physician to do something that is not required by standards of reasonable medical practice. The law does not require a physician to act "defensively," only "reasonably." If, on the other hand, the concept of defensive medicine is, in fact, describing conservative and thorough standards of medical practice, then to the extent the law has prompted such an attitude, it is a welcome development and indicates the extent to which the common law can serve in a salutory capacity to improve the standards of quality medical practice.

I hope that in its important work, this Committee will carefully consider the effect of criticism and proposed changes in our system on health care consumers and that it will deal with those factors which seem to underpin quality medical practice.

Senator **Quayle**. Thank you.
Alvin Bakst.

STATEMENT OF ALVIN A. BAKST, M.D., CHIEF OF SURGERY, JOHN F. KENNEDY MEMORIAL HOSPITAL

Dr. **Bakst**. Senator Quayle, I rise from the trenches to appear before you and thank you for the kindness of your invitation. I am presently the chief of surgery of the John F. Kennedy Memorial Hospital, and I am also the chief of thoracic and vascular surgery at that hospital. It's a subsidiary of National Medical Enterprises in California.

Prior to moving to California, I was the full professor of thoracic and cardiovascular surgery at Flower Fifth Avenue Hospital, which is in New York City, and I had the opportunity to chair the Malpractice Committees both of the Nassau County Medical Society in Mineola, Long Island and the Kings County Medical Society in Brooklyn, NY. At that time the purpose of both committees revolved around an attempt to curb, in effect, the growing trend of malpractice. I'm talking about many years ago.

We found that the average juror did not truly comprehend the deep complexities of a medical case, and we attempted to circumvent a trial by jury. We sat with both plaintiffs' and defendants' attorneys, as well as with a judge. The plaintiff's case would be presented; it would be evaluated dispassionately. If we found that there was negligence or substandard care, we immediately recommended to the insurance company, and to our insurance company, that there be a settlement on an equitable basis, thereby mitigating the expense of a rather complicated lawsuit.

On the other hand, if we found that there was no negligence involved and that the plaintiff's case revolved around a bad result, it was our advice that it be discontinued. Frankly, despite hours and hours and weeks and weeks and months and months of care, we did very little to curb or change the problem. We attempted arbitration; that's been attempted on a national basis, both by way of physicians and by way of hospitals, and to date has really been a failure. It has not curbed the malpractice problem.

Originally there was an attempt to define malpractice legally as involving substandard care and substandard conduct. More simplistically, it required demonstration of negligence. However, there are all too many gray areas and all too often, malpractice tends to revolve around little more than a bad result or a disgruntled patient. This is not to say that there is no malpractice; I don't mean to imply that. I do mean to say that there is a large segment of the malpractice trade, so to speak, which does not revolve around negligence.

It then seemed that it might be efficacious to attempt to curb the ability to initiate suits. This, of course, is impossible and should not even be considered.

Originally, malpractice, per se, represented a problem left to the physician alone. The insurance companies were forced to protect contingency funds, which resulted in a rapid increase in premiums. This added to the cost of medicine, but minimally so. Doctors' fees were increased but not significantly enough to warrant change in health care. However, over a period of years the spectre of malpractice has gradually led to a more insidious augmentation in the cost of medical care—this not to the doctor, but to the hospitals and through a group of third-party carriers, as well as to the Government.

In truth, the pattern of practice on the part of the physician has changed as he has perceived the threat of malpractice. The physician has entered into the area of practicing defensive medicine. Batteries of laboratory studies are ordered. These studies may or may not be indicated or necessary, but they are ordered lest a physician be embarrassed by an attorney at some subsequent date.

Moreover, we now have a new era of consultative medicine. This is new. It was called, cover your flanks. Consultative advice is frequently requested to cover each disease system. Each consulting physician, now a specialist, must protect himself as well and order his own battery of specialized tests and studies. We have surreptitiously changed the pattern of the practice of medicine and have thrown a massive cost factor upon both third-party carriers, as well as to the Government itself.

The practice of medicine is complicated. In the interests of time, let me say that originally the threat of malpractice was perceived to be a physician problem. It no longer is so. It has snowballed to monstrous proportions, and it has changed the health care system. It represents a threat to us, and it's so serious that this may well be a significant factor in its destruction.

Are there any answers to this complicated morass of questions? We have a litigious society. Contingency fees are appropriate. Doctors do, on occasion, have negligence in their profession. Most importantly, many diseases terminate unfortunately despite the very best of medical care.

I believe that, at the present time, the Government is attempting to affix a new approach to health care itself. They've evolved upon DRG's as a system for hospital reimbursement; why not embark upon an original means of controlling litigation as well? Let's consider a modified form of no-fault insurance. We already have guidelines for these; they've been set in the field of personal injury. There are fixed formulas for reimbursement for an injury. Let's reject such claims as pain, suffering, grief, loss of cohabitation, et cetera. Let's attempt to rule out the deep pocket theory.

As an alternative, one might also consider the implementation of a form of casualty insurance whereby the patient, his union, and his medical coverage will limit the liability of his choice, as well.

In conclusion, I'd like to express my appreciation to you for your graciousness in this invitation. If you are ever to need me, I'd be happy to be called again in the future.

Thank you.

[The prepared statement of Dr. Bakst follows:]

ALVIN A. BAKST, M.D., F.A.C.S.

72-705 HIGHWAY 111, SUITE 5
PALM DESERT, CALIFORNIA 92260

July 6, 1984

Senator Dan Quayle
254 Senate Office Building
Washington, D.C. 20510

Re: Labor Committee Hearing on Defensive Medicine

Dear Senator Quayle:

In introduction, I am presently the Chief of Surgery and the Chief of Thoracic and Vascular Surgery at the John F. Kennedy Memorial Hospital, a subsidiary of National Medical Enterprises in California.

Prior to moving to California, I was the full Professor of Thoracic and Cardiovascular Surgery at the New York Medical College, Flower Fifth Avenue Hospital in New York. At that time, I served as Chairman of the Malpractice Committee of the Nassau County Medical Society in Mineola, Long Island and also chaired the Malpractice Committee of the Kings County Medical Society in Brooklyn, N.Y.

The purpose of both committees revolved around an attempt to curb the growing trend of malpractice. We sat with plaintiff and defendant attorneys as well as with a judge. Plaintiff's case would be presented and evaluated dispassionately. If negligence or substandard care was thought to be involved, our recommendation was for settlement on an equitable basis, thereby mitigating the expense of a rather complicated lawsuit. If, however, the litigation revolved around a bad result without evidence of negligence, it was our advice that it be discontinued. Frankly, despite tremendous time, effort and care, we did little to curb or change the problem.

Medical malpractice is an extremely complicated affair. There are no easy answers.

There was an original attempt to define malpractice legally as involving substandard conduct and care. More simplistically, it required demonstration of negligence. However, there are all too many gray areas and all too often malpractice may revolve around little more than a bad result of a disgruntled patient. In a society where there is a demand for product warranty, health care may be considered and evaluated by the result. A bad or unsuccessful result may therefore be equated to substandard care. It would then seem to be efficacious to attempt to curb the ability to initiate suit. This has proven to be impossible. The attorney usually offers his services on a contingency basis. Whereas this does extend legal aid to the financially unfortunate, it also tends to increase the cost of settlement to the insurance company since most attorneys accept 30-50% of the award as their fee.

Originally, malpractice per se represented a problem left to the physician alone. The insurance companies were forced to protect contingency funds which resulted in a rapid increase in premiums. This added to the cost of medicine, but minimally so. Doctor's fees were increased but not significantly enough to effect the health care system.

However, over a period of years, the spectre of malpractice has gradually led to a more insidious augmentation in the cost of medical care. This, not to the doctor but to the hospital, the group of third party carriers and to the government itself.

The pattern of practice on the part of the physician has changed as he perceived the threat of malpractice. The physician entered into the area of practicing defensive medicine. Batteries of laboratory studies were ordered, lest an attorney questioning the physician on the witness stand raise his eyebrows and ask, "Doctor, did you order a blood placebo level? What, you didn't order a blood placebo level!" The effect upon a jury is obvious. Little matter that a blood placebo level was neither indicated or relevant.

All laboratory nonsensical tests became imperative and subsequently massive batteries of laboratory studies evolved.

Moreover, a new era of consultative medicine evolved. This was called, "cover your flank." Consultative advice is requested to cover each disease system. Each consulting physician now must protect himself as well and order his own battery of specialized tests and studies. We have surreptitiously changed the pattern of practice of medicine and have thrown a massive cost factor upon both third party carriers as well as the government itself.

However, even here the practice of medicine is complicated. The country has disparate and dissimilar population factors. Doctors have varied profiles. The scale of payment differs widely.

In many retirement communities where the aging population congregates, we find a high incidence of multi-system disease. Complicated workups are necessary. The care is more complicated. The incidence of serious complications is higher and requires more specialized evaluation and length of hospital stay.

Again, the cost of the health care system must increase if it is to do little more than reflect the increasing level of sophistication of medical advances. The acute coronary goes to the coronary care unit where he is monitored around the clock. The patient with renal failure receives dialysis regardless of age. This, in contradistinction to the careful evaluation and rejection of patient categories in the English system of health care. Are we to reject medical care because of age? Hardly so!

Nevertheless there has been a gradual, insidious change from the practice of medicine to the practice of defensive medicine. The cost to the health care system has grown in logarithmic proportions.

Suffice to say that the threat of malpractice, originally perceived to be a physician problem, has snowballed to monstrous proportions. It has suddenly changed the health care system, and represents a threat to it, so serious, that it may well be a significant factor in its destruction.

Are there any answers to this complicated morass of questions?

We have a litigious society.
Contingency fees are deemed appropriate.
Doctors are not specimens of perfection.
Many diseases terminate unfortunately despite the very best of medical care.

The legal profession constitutes a group of brilliant minds with keen perception. It is this very group that we may well be required to turn to for guidance and leadership.

It is my personal conviction that in view of the above, it is necessary for the government to address itself to this problem in a new, original and dynamic fashion. The government has not hesitated to attempt to control the cost of health care. They have evolved upon DRG's as a system for hospital reimbursement. They are making strong attempts to fix the cost of medicine.

Why not embark upon an original means of controlling litigation as well?

Let us consider a modified form of no fault insurance. We already have guidelines for same. These have been set by the field of "personal injury." Here there are fixed formulas for reimbursement for an injury. The loss of a limb is worth so much, an arm so much, an eye so much, a life so much. Each is given a fixed value with fixed areas of limitation. Let us reject such claims as pain, suffering, grief, loss of cohabitation, etc. Let us rule out the deep pocket theory. Let each defendant be financially responsible only for his fixed percentage of fault regardless of the financial ability of the other defendants in a case.

Let us define and fix and limit reimbursement for the plaintiff in no fault fashion. This will require much careful thought and consideration but it will work if properly defined.

May I express my appreciation to you for your graciousness in extending this invitation for me to address your committee.

Respectfully,

Alvin A. Bakst, M.D., F.A.C.S.

AAB:sk

PHYSICIANS'S PROFESSIONAL LIABILITY RATES

Following are rates quoted by several companies in reference to medical malpractice insurance in the four specialties named below. All of the following are based on $1,000,000 per occurence with $3,000,000 in the annual aggregate. The quotes are based on plans for either five or six years, and are not retroactive.

CO-OP OF AMERICAN PHYSICIANS

This program includes an initial trust fund which varies according to the specialty. A portion of the annual premium is to be applied to the trust fund which will be available to the physician within a 10 year period. The premium for the first year includes a $200. application fee.

Thoracic	General	Family Practice	OB-GYN
$7,631.	$2,420.	$1,795.	$8,515.
8,797.	2,808.	1,986.	9,822.
11,520.	3,700.	2,555.	12,281.
14,781.	4,958.	3,357.	15,752.
11,414.	6,633.	4,420.	12,789.
Initial Trust Fund:			
$25,000.	$10,000.	$7,000.	$28,000.

CNA PROGRAM

Thoracic	General	Family Practice	OB-GYN
$6,624.	$6,624.	$2,316.	$7,736.
10,604.	10,604.	3,556.	12,472.
13,932.	13,932.	4,596.	16,418.
15,964.	15,964.	5,228.	18,832.
16,824.	16,824.	5,496.	19,857.

SCPIE

Thoracic	General	Family Practice	OB-GYN
$ 7,556.	$ 7,556.	$2,100.	$10,492.
14,240.	14,240.	3,772.	19,128.
18,380.	18,380.	4,804.	24,012.
20,432.	20,432.	5,320.	26,432.
22,024.	22,024.	5,720.	28,308.
22,764.	22,764.	5,904.	29,184.

ST. PAUL INS.*

Thorcic	General	Family Practice	OB-GYN
$22,751.	$18,976.	$3,378.	$24,524.

*The above quoted rates are for active staff of J.F.K. Memorial Hopsital and may be lower than the normal rates.

Senator QUAYLE. Thank you very much.
Isaac Sultan.

STATEMENT OF ISAAC SULTAN, M.D., DIRECTOR OF NEUROLOGY, JOHN F. KENNEDY MEMORIAL HOSPITAL

Dr. SULTAN. Senator Quayle, may I thank you for your gracious invitation to appear before you.

For the record, I am a practicing clinical neurologist who is chairman of the professional liability committee at John F. Kennedy Memorial Hospital in Indio, CA, near Palm Springs. I have dealt with the question of malpractice insurance and its relation to health care for several years; I am sure that I am representative of my counterparts nationally.

I appear here to address the question of defensive medical practice and its relation to augmentation of health costs. What can be done? Doctors are fearful and practice defensive medicine to protect themselves from attorneys who search for minute deviations from accepted care. Physicians therefore will oversecure radiological studies, blood tests, and pathological studies although the likelihood of it being beneficial to the patient is minuscule. Not only will they search for the obvious diagnosis and rare one, but they also search for the ultrarare, highly improbable diagnosis just to protect themselves. They will ignore their clinical impression just to provide objective evidence that all lab and other medical chores were performed. In so doing, when a malpractice attorney's letter comes, the doctor has prepared the record and himself in thorough refutation. The inevitable consequence of this style of practice is an almost logarithmic escalation in medical costs.

There is no easy solution to this dilemma. I offer a direction of thought: Let us think of the means to isolate a doctor from a capricious legal misadventure. We deal with a litigious society. Render it increasingly difficult to bring suit. Remove the windfall incentive by placing caps on awards that can be granted according to a fixed, sliding scale, as has been initiated in the State of Indiana. Erase the deep pocket incentive where an attorney is allowed to bring suit to a physician or hospital even remotely involved with a case. As an example, the following case should be brought to your attention.

An anesthesiologist who was bare, with no insurance, had intubated a patient's esophagus and not his trachea, in error. The patient subsequently suffered severe, irreversible brain damage. The anesthesiologist was found to be 99 percent liable for the tragic incident during surgery. The general surgeon, who was only 1 percent liable for the tragedy, had to pay the entire judgment through his insurance carrier because he was the only one who was insured. It is my feeling that awards should be limited to a reasonable, preselected level rather than to the capricious whim of a jury.

Senator, I have prepared a common case history to illustrate how members of my specialty fall victim to defensive medicine. Other subspecialties in medicine have similar scenarios.

A 22-year-old female on a Sunday afternoon horseback ride suddenly gets thrown. She is uncertain whether or not she lost consciousness. She complains of headaches and dizziness, otherwise feels fine. At the request of friends and family, she goes to the local emergency room where a neurologist is contacted. The neurologist quickly postulates that because her strength, sensation, reflexes, and mental status are normal, no major neurological problem is present. He reasons to himself that although he is 95 percent certain all is well, to be even more accurate, one of two responses can be taken. He could either follow the patient's physical examination in his office frequently or hospitalize the patient, observing and objectively investigating her with appropriate neurodiagnostic studies. The latter approach of hospitalization is usually chosen because of the following reasoning: If the patient is discharged, compliance with office followup might be poor. Another horseback riding episode may occur, only this time resulting in a fall and brain hemorrhage. The patient might then be seen by another neurologist at another hospital, with a probable visit to a malpractice attorney. Our neurologist imagines being confronted with the following difficult retrospective questions: Can he be certain that the hemorrhage was not present with the first fall and, more importantly, a causative factor of the second? Why didn't he perform a neurodiagnostic evaluation, which was readily available?

And so, Senator, hospitalization with a costly evaluation occurs. With the CT head scan, EEG, skull x rays and blood tests, the final cost is significant—in the thousands of dollars.

In my specialty, numerous other examples can be brought forward. The middle-aged executive who plays golf for the first time in years unfortunately injures his back. A costly evaluation might occur where conservative treatment would have sufficed. The young housewife with several children who complains of a myriad of symptoms including headaches, dizziness, visual disturbance, tingling of the extremities, just to mention a few, usually ends up with the largest bill of all because of a medicolegally motivated attempt to objectively evaluate each symptom with appropriate tests.

Future proof was needed that all that could have been done was done.

Senator, when I was asked to appear here, I was pleased not only with the possibility of being a contributor to lowering health care costs, but more importantly, having the opportunity of increasing the quality of medical care in this country. It is my feeling that if you change the law so that physician apprehension is reduced, the rationalization that defensive medicine is high-quality medicine will be replaced by a new truth more compatible to physicians. High-quality medicine is medicine that is practiced in an economically feasible fashion.

And so, Senator, remove the motivation for practicing defensive medicine and medical costs will decline.

One other thing. You asked previously an important question, "Will the quality of medicine subside if we eliminate the fear of malpractice?" The answer is "No." The quality of medicine will be increased. As Hippocrates said, "First, do no harm." Needless x rays would be avoided, decreasing the risks of radiation. Shorter hospitalizations will result, and less hospital-acquired infections. But most importantly, you will eliminate the cloud of fear hanging over a physician's head.

I ask you, Senator Quayle, doesn't any human being work better when a cloud of fear is removed?

Thank you.

Senator QUAYLE. Do you agree with Mr. Bakst that we need to have a national no-fault type of coverage?

Dr. SULTAN. Yes. I think it is an excellent idea.

Senator QUAYLE. You both indicate that the sole reasoning or response for a lot of this expensive, so-called defensive medicine is strictly for protection against potential lawsuits and not for any medical purposes.

Dr. SULTAN. No; I think that——

Senator QUAYLE. Is that what you're saying?

Dr. SULTAN. Well, I think that it's a combination but I think that the practice of defensive medicine has a large part of that.

Senator QUAYLE. Is there a medical value to defensive medicine?

Dr. SULTAN. There is medical value in that it looks for the ultrarare, the very rare diagnosis. So, in essence, you could say, "Well, isn't it our obligation as physicians to rule out disease with as close to 100 percent certainty as possible?"

So in that fashion, there is justification in practicing defensive medicine.

Senator QUAYLE. Where are you going to draw the line? Either it is of some medical value, or there is no medical value. I am a little bit confused here, because I just asked three other physicians—they represented physicians, but they were physicians as well—and they all sort of indicated to me that defensive medicine, as such, certainly has some medical value. They said that a contributing factor was the potential of malpractice suits, but that certainly wasn't the sole factor or the major factor for putting forth some of these tests.

Now you're telling me basically the opposite, that these things would not be going forward unless you had that lingering potential of malpractice suits.

Dr. **Sultan**. Senator Quayle, it has to be taken in a case-by-case situation; and the example that I presented with the horseback ride, the subsequent approach taken by the physician was one of defensive medicine in mind. I would say that the value of defensive medicine is to search for the rare diagnosis, as I have stated.

Senator **Quayle**. So there is some value?

Dr. **Sultan**. There is some value. If I led you to believe that here was not any value——

Senator **Quayle**. I just sort of got the impression that defensive medicine—that there were no positive aspects to it, and that we really shouldn't be doing it and it's sort of a nuisance and very troublesome.

Dr. **Bakst**. Senator Quayle, if I may, I think that the perception that you've just thrown to us is the concept that defensive medicine, per se, is something that we have said is of no value. That's not quite what I'm trying to imply.

Senator **Quayle**. Little value.

Dr. **Bakst**. What I tried to imply is that the entire concept of the practice of medicine has changed, and that a doctor doesn't perceive a patient the way he did previously. A doctor now looks upon a patient as something which, number one, has got to be cured and treated; but number two, he also has had any number of lectures from the attending malpractice attorney in the area who advises him as follows: No. 1, have good patient relations. Well, we try to anyway. No. 2, be absolutely certain that the chart is impeccable. And now you find a physician who spends more time with the chart. No. 3, ascertain that if there is a study which should be performed or which could be questioned, that you do it.

We don't have individual studies any more. When we come in, we order a battery of tests. A group of studies which we really don't even conceive of, think we need, or comprehend as being necessary; but initially, when that patient hits the hospital, in recognition of time, in recognition of the fact that this chart will be reviewed possibly by some adverse individual, that everything be covered; and that's the part of it which is unnecessary. We secure consultative advice that really may or may not be necessary. In many areas it is, don't misunderstand me, but we practice in an area where there is an elderly or an aging population and these people have multisystem diseases. Nevertheless, they come to the hospital for an illness; yet it's incumbent upon us to ascertain, when that individual reaches the hospital, that each aspect of that multisystem disease is addressed whether it is the reason for their hospitalization or not. So we might end up with six or seven high-type, high-powered consultants to address phases of that individual's illness for which they have not been hospitalized lest there be a complication and we be criticized.

I can give you an example. A 78-year-old man comes to the hospital who has an inguinal hernia to have it repaired. He's got heart trouble and he's got kidney trouble and he might have had a stroke in the past, et cetera. The operative procedure is going to be a 48- or a 72-hour procedure. He'll be in and out of that hospital rapidly; it will probably be performed under a local anesthesia. But he will have had a cardiac consultant, he will have had a nephrologist in there, he will have had a neurologist in there, all of them to ascertain that should there be a problem, should he postoperatively have a cardiac arrythmia, that we would not be faulted in that we went ahead and proceeded with a procedure without having had proper consultative advice and, therefore, standby. That's what I mean to imply.

Senator **QUAYLE**. Mr. Shrager, do you want to——

Mr. **SHRAGER**. Yes. I think it may inadvertently do a disservice to many physicians who have, as free-standing propositions, recommended mandatory consultations before surgery, for example, to pass off defensive medicine as something that is really not very important in the whole factor.

Let me reiterate. Under our law, our system of justice does not look for the rare, for the arcane. It looks for reasonable standards of conduct, and it obtains those reasonable standards of conduct not out of the imagination of lay persons but by having, accessing, medical folks who have a chance to have their say before a group of jurors. Out of that comes the application of the concept of reasonable care. When we look back over the history of medicine in the last decade and observe the more critical use of surgery, the more frequent use of consultations, the almost universal use, for example, of instrument counts—I can recall a time when open-heart surgery first started, when there were, on certain forms, space for sponge counts, but they didn't quite catch up in terms of the hardware yet, but now that's probably well behind us in most instances—we see many, many fine examples where the law has served a role, as has the quality of medicine, in pushing the standard of care forward.

Also we have seen it, Senator, in terms of the interdisciplinary use of medical personnel in treating the geriatric patient. I am not sure that the example that we heard before, of the elderly patient, may not have proved too much. I wonder what the perception of the patient and his family would have been had, indeed, he walked out of the hospital and within 24 hours been the victim of a cardiac arrest, which could have been discerned through the use of a routine EKG during the admission.

But again, the focus should not be on extreme cases. It should not be "war stories." It should not be the case that apparently is the abuse of the system, or even the apparent horror story of the patient who is maimed by an intoxicated physician. That's not what it's about. We ought to look at it in terms of the broad mainstream of what there is to learn from these cases. What I think we'll observe is that the benchmark of reasonable care, which is what is required under our law—not super care, reasonable care—has worked rather well in resolving these disputes and, we think, in serving to increase the quality of medical practice.

Senator **QUAYLE**. Let me just ask one question, Mr. Shrager, getting back to this contracting.

Mr. **SHRAGER**. Yes.

Senator **QUAYLE**. I certainly understand the tenets and principles of contract law and arm's length and under duress, and I think that the concerns that a lawyer would have under this are legitimate. But on the other hand, it seems to me that if you really want to get the social goals of more rapid payment, more expeditious and perhaps more efficient, the utilization of putting the plaintiff back to where he or she ought to be before the injury—it occurs to me that this contracting is not something that ought to be dismissed because it's going to be difficult to effectuate on a legal basis. I just wonder, given that understanding—if you look at some of the social goals, that there might be some maneuvering room in this area of private contracts, particularly as you get into some of the PPO's and HMO's and that type of situation.

Are you in the position to really resist this type of innovation?

Mr. **Shrager.** I wouldn't be in the position to, nor should I, resist any step that has the promise to offer a forum or any modality which, without compromising citizens' rights within our adversary system, could offer the opportunity for benign, prompt, and informal resolution of claims.

Let me just share an approach that you might be interested in in this respect, since I gather that you are using the example of a contract as an effort to see whether something could be used, at least in an ancillary capacity, to the traditional tort system.

We have, in our country, many devices involved in dispute resolution; in fact, I hope you will take the opportunity, as I know the committee will, to learn from court administrators and judges around the country about those devices. For example, in the City of Philadelphia, 25,000 cases a year are being handled within about 6 months from the date the claim is filed through the expedient of arbitration. People come in, informality of proof, and tell their story. You don't have to bring in experts; you can use reports. The appeal rate is 10 percent, so lawyers on both sides, parties on both sides evidently respect the system. That has worked as a dispute resolution device ancillary to the right of every litigant to seek trial by jury if he or she is not happy or pleased with the result. It handles cases up to $20,000. It's a forum where people can come and share their complaints. It's the use of the system, Senator, as a great pressure relief system.

There are mediation panels which, if they operate fairly—that is to say, if cases will be screened and if, for example, the medical care providers in the event of a meritorious claim are willing on a fee-for-service basis to step forward and serve as expert witnesses—can work. Again, citizens can meet together and share in an informal forum.

There are pretrial conferences that are used on an increasing basis to expedite, in judges' chambers, these claims.

There are a whole host of things that can and have been done, and I'm sure we could do much better.

Let me just share with you finally a reference that I hope your staff will be able to share with the rest of the committee. It's a very important study. The first empirical study has been undertaken that we know of in this country in terms of dispute resolution, and it includes medical negligence claims. It's the civil litigation research project that was undertaken by the University of Wisconsin, and it was published in the UCLA Law Review, I believe, in the last December and January issues. It deals, again, on the basis of a scientific polling protocol with the perceptions of citizens, including health care consumers, to the system and shares how the system is doing. It gives it pretty high marks but at the same time, it talks about other devices and encourages the use of these other devices.

Senator **Quayle**. OK.

Senator **Quayle**. This concludes the hearings, and I certainly thank the panel members and all the witnesses.

The committee is adjourned.

[Whereupon, at 12:30 p.m., the committee recessed, to reconvene at the call of the Chair.]

[Additional material supplied for the record follows:]

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Summary of Bills and Glossary

S. 2501: The Public Health Service Act Amendments of 1984:

Sec. 2. Renames Title XIII of the Public Health Service Act to read "Health Maintenance Organizations and Alternative Payment and Delivery Systems."

Amends Section 1310 of the Public Health Service Act to allow employers required under the Act to provide employees with an HMO option to provide either an HMO or CMP option. For the purposes of these amendments CMPs are defined by Section 1876 of the Social Security Act.

Amends Section 1311 of the Public Health Service Act to provide CMPs the same waivers from state restrictions as provided under the Act currently for HMOs.

Sec. 3. Amends Section 1311 of the Public Health Service Act to waive certain state laws which prohibit insurers or other third parties from providing preferred provider arrangement-type health plans. The amendments provide that agreements shall not allow discrimination for other than economic and quality of care considerations.

Sec. 4. Amends Section 1310 of the Public Health Service Act to require employers to provide employees with reasonable access at least once per year to a blood pressure test. This provision does not require that employers offer the test under a health plan.

S. 2502: The Medicare Preferred Provider Arrangement Act:

Sec. 2. Amends Part B of Title XVIII of the Social Security Act to allow the Secretary of Health and Human Services to contract with insurers or other third party payers so that Medicare Part B enrollees can participate for Part B benefits in a preferred provider arrangement. The payment levels, requirements on providers and protections for beneficiaries provided in this amendment are modeled on Section 1876 of the Social Security Act which allows the Secretary to contract for Medicare beneficiaries with HMOs and CMPs.

S. 2503: The Health Care Consumer Information Act:

Sec. 2. Requires the Secretary of Health and Human Services to:

1. conduct a study of the effects of efforts to provide price data to third party payers and consumers of health care services;
2. develop methodologies for providing third party payers and consumers with price data with respect to ambulatory health care services; and
3. develop methodologies for providing consumers with information with respect to the quality of health care services.

S. 2504: The Institute for Health Care Technology Assessment Act:

Sec. 2. Facilitates the establishment of a private nonprofit institute to be known as the "Institute for Health Care Technology Assessment." The purpose of the Institute shall be to promote the development of appropriate health care technologies and the application of approved technologies, and promote the elimination of obsolete or inappropriate health care technologies. The bill identifies a set of organizations which will send representatives to serve on the Board of the Institute and write its by-laws. The Secretary of Health and Human Services and the Director of the Office of Technology Assessment will serve as ex officio members of the Board. The Institute will have at its disposal a 2 million dollar line of credit made available by the Secretary.

Glossary:

Health Maintenance Organization (HMO)

A health plan which provides comprehensive medical services to beneficiaries on the basis of a fixed premium. Employers are required by law to provide employees with the option of coverage by a federally qualified HMO if one is available in the near vicinity of the employer. To become federally qualified, an HMO must provide a fixed scope of services, a specified organizational and management structure and meet certain financial requirements.

Competitive Medical Plan (CMP)

A health plan similar to the HMO which will be paid by the federal government for Medicare beneficiaries. A CMP may offer a more limited scope of benefits to its beneficiaries than an HMO and have less regulated organizational and financial structures.

Preferred Provider Arrangement or Organization (PPA)

A health plan in which physicians and hospitals contract to provide services to a set group of beneficiaries on a fee-for-service basis. These contracts may be with union trust funds, employers or insurers. These contracts may include discounted fees and/or strict utilization review requirements. In return, providers are paid faster and are assured a larger volume of patients. Beneficiaries agree to choose physicians or hospitals contracting with the PPA in return for reduced out-of-pocket expenses.

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FOR IMMEDIATE RELEASE
April 2, 1984

QUAYLE UNVEILS PACKAGE OF FOUR BILLS TAKING INCREMENTAL APPROACH TO HEALTH-CARE COST-CONTAINMENT

INDIANAPOLIS, IN -- Insisting that "the incremental approach is the best way to achieve the reductions we so urgently need to make in our nation's soaring health bill," Senator Dan Quayle (R-IN) Monday outlined the provisions of a major health-care cost-containment package he introduced in the U.S. Senate last Thursday.

"Health care costs increased twelve-fold -- from $26.9 billion to $322.4 billion -- between 1960 and 1982," the Indiana Republican said in a speech here at the Indiana University School of Nursing. "Yet during that same period, the consumer price index increased by a little over two-fold. We simply must take steps to curb these spiralling health costs -- but we must do so in a way that does not hinder the quality of available care or the access to health services that our citizens deserve and demand."

Quayle, a member of the Senate Labor and Human Resources Committee, which has jurisdiction over health legislation, explained the philosophical thrust of the four bills he has offered: "Cost-control solutions must be developed that change the incentives to consumers, hospitals and physicians without applying burdensome sanctions, which will only lead to the deterioration of our health care system. To change these incentives, I believe we must undertake sound incremental reform rather than system-wide federal regulations aimed at capping costs.

"The incremental approach I advocate," the Indiana Senator continued, "includes market-oriented policies designed to encourage consumers, hospitals, physicians and insurers to be more cost conscious in their health-care expenditures. These market-oriented initiatives should promote a healthy competition between hospitals and physicians on the delivery level, and third-party payers on the financing level, while making consumers more aware of the economic implications of their health care purchasing decisions. And in any event, initiatives to contain health care-costs must account for a myriad of economic, social and political factors, recognizing the idiosyncracies of our generally decentralized and pluralistic but high quality health-care system."

Quayle said the four bills he has introduced "will serve to reduce our nation's health-care bill at the margin."

One of the measures, S. 2501, the Public Health Service Act Amendments of 1984, would promote the development of alternative health-care delivery and financing systems. In addition, by requiring employers to provide employees reasonable access to blood pressure tests once a year, the bill would help save lives and health-care costs by alerting those suffering from hypertension to take steps to lower their risk of stroke, heart attack and other cardiovascular diseases.

The second of Quayle's bills, S. 2502, the Medicare Preferred Provider Arrangement (PPA) Act, would promote the participation of insurers, employers, hospitals and physicians in PPAs. Under the PPA model, a relatively new health-care delivery and financing system, insurers, employers or other third party administrators contract directly with physicians and/or hospitals that agree to provide health services in a cost-conscious manner or even at a discount to payers under strict utilization controls. In exchange, payers promise prompt payment to contracting hospitals and physicians, as well as financial incentives for beneficiaries to patronize these preferred providers. Quayle's bill would enable Medicare Part B enrollees to participate in PPAs for Part B benefits.

The third Quayle initiative, S. 2503, the Health Care Consumer Information Act, is premised on the Indiana Senator's conviction that, "for health care to become more competitive, consumers and insurers must have access to easily understood and relevant data on both the cost and quality of services." The bill would require the Secretary of Health and Human Services to conduct a study of the effect price information programs already underway have had in health-care marketplaces around the country. The bill also calls for studies of ways to provide price data on ambulatory services and data on the quality of health-care services generally to third party payers and consumers.

The fourth bill in the package Quayle introduced last week, S. 2504, the Institute for Health Care Technology Assessment Act, is designed to help the health-care system better evaluate current, new and emerging technologies in medical and economic terms. The private, non-profit Institute to be created by Quayle's measure would facilitate the development of appropriate health care technologies and the application of approved technologies, and it would also promote the elimination of obsolete or inappropriate health-care procedures or equipment. Run by a board of directors that would include representatives of insurers, hospitals, health-care professionals, management, labor and senior citizens, the Institute would receive a line of credit from the Secretary of Health and Human Services for its formative period and be responsible for its own financing thereafter.

"Good technology assessment," Quayle explained, "will help eliminate ineffective and possibly harmful technologies, lead to a reevaluation of variations in treatment and diagnostic testing, provide a better understanding of the outcomes of treatment and diagnostic testing and their efficacy across larger populations, and provide background for benefit-cost assessments of technologies. The information provided through the assessment processes facilitated by the Institute would assist the individual consumer, health providers and payers, as well as the largest single payer of all, the federal government."

# # #

TESTIMONY BY

ESTHER BOOTH ZORN, FOUNDER/PRESIDENT

CESAREAN PREVENTION MOVEMENT, INC.
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ON

THE PRACTICE OF DEFENSIVE MEDICINE AND ITS EFFECTS ON THE QUALITY OF MEDICAL CARE

July 10, 1984

On behalf of the Cesarean Prevention Movement, Inc. (CPM), I am pleased to discuss the practice of defensive medicine by the medical profession in an effort to avoid malpractice suits and its effects on the quality of medical care. My comments are directed to one aspect of this important problem, the practice of performing medically unnecessary cesarean sections.

The cesarean rate in this country has risen 400% in the last ten years. It now approaches 20% of all deliveries nationwide and in many hospitals stands at 30%, 40% and even 50% of births. CPM, a national nonprofit organization, was founded in 1982 out of concern that many of these cesareans are not performed for sound medical reasons. Our purpose is to educate and support women to avoid an unnecessary cesarean. We help first time mothers to avoid a first cesarean if possible and provide support and educational materials to women who wish to pursue a vaginal birth after cesarean (VBAC).

CPM recognizes that cesarean section, appropriately used, is a valuable medical technique to save either or both mother and child. However, the experience of other countries, many with both lower infant and maternal mortality rates than that of the United States, indicates that a reasonable cesarean rate is closer to 5%.

These unnecessary surgeries represent an enormous cost to medical consumers and the public. Because of our faith in medical science and the prevalence of these operations, physicians and sometimes the public have apparently come to view a cesarean as a benign procedure, one which is no riskier than childbirth in general. In fact, the risk of death for a cesarean mother is 2-4 times that for a vaginal delivery and, according to one study, 27 times as high. We can no longer tolerate our 20% national cesarean rate.

The increase in cesarean births appears to have no benefits for the women and babies involved. A decrease in the perinatal mortality rate which has occurred over the same period in which our cesarean rate has reached such shocking proportions is often claimed as a benefit of the increased surgical intervention. In fact, the maternal and infant mortality and morbidity rates have not lowered as a direct result of this substantial increase in the cesarean rate. A similar decrease in the perinatal mortality rate has occurred over the same period in countries in which the cesarean section rate has remained around 5%. A better explanation for the improved perinatal mortality rate is the increased availability of perinatal intensive care centers. In other words, the increase in cesareans is not saving more babies, but it is hurting more mothers.

A majority of these additional cesareans are being done not for medical reasons but for legal reasons. A report to the Department of Health, Education and Welfare five years ago, done by Dr. Helen Marieskind, listed the threat of malpractice suit as the reason given most often by doctors for their increased use of cesareans over the preceding decade. Recently the American College of Obstetricians and Gynecologists (ACOG) surveyed nearly 2,000 obstetricians/gynecologists across the United States. According to Dr. James Breen, ACOG President, the two major findings of the survey were

> first, medical malpractice actions definitely do increase the cost of health care, and many physicians reported changes in their practice because of a fear of malpractice suits.

Obstetricians face a high rate of malpractice suits, second in the medical profession only to anesthesiologists. Under these circumstances it is easy to see why doctors would substitute surgery for the known risks of more traditional procedures. Yet according to a 1984 Ob.Gyn.News statement, "Seventy percent of medical malpractice suits stem from surgery." In the same article, Elvoy Raines, J.D., associate director of ACOG's department of professional liability, at a seminar on medico-legal dilemmas in obstetrics and gynecology, urged obstetricians to take care to perform cesareans for medical not legal considerations, a recommendation CPM would endorse.

This is a problem of enormous magnitude. The NIH study and numerous medical articles state that at least 75% of the 750,000 women who have surgical births each year qualify, medically, for a trial of labor, and 65% of those women will have normal births with no increase in risk for either mother or child. In fact, only 2% of women who have had a cesarean, including those for nonrepeating reasons such as fetal distress or breech presentation, are allowed a trial of labor. For the remaining 98% of cesarean mothers, the outdated adage, "once a cesarean always a cesarean," unfortunately applies.

The 1979 HEW Report, a 1982 NIH Task Force Report and even ACOG's VBAC guidelines have urged lowering the cesarean rate, especially the 98% automatic repeat cesarean rate. We see little evidence of this happening, except as a result of pressure on the medical community. Repeat cesareans represent a $94 million industry each year, about 49% of which would be lost if all mothers at good risk for a VBAC were permitted a trial of labor. This $94 million represents the increased time of hospitalization from a typical three days to an average of seven, as well as the increased obstetrical and anesthesia fees. It does not include the cost of replacing a mother's services in the home or at work or such intangibles as her absence from her husband and children or the psychological effect of major surgery to have a baby.

The short and long term effects of the current malpractice crisis seriously harm all involved: pregnant women, their babies, the physician, and the hospital. Thus, all involved have a responsibility to find a solution. We suggest the following:

1. Women must take active responsibility for their health and that of their babies. The chance of a normal, healthy birth experience in today's overmedicalized, technology-oriented birth environment is improved by information about the benefits and risks of obstetrical procedures and drugs.

2. Obstetricians must communicate more openly and honestly with their pregnant patients. No one can guarantee a perfect outcome, but giving detailed information and involving a woman in her own care promote better compliance as well as truly informed consent.

3. State and county review boards need to question such practices as routine repeat cesareans, overuse of medical technology, and first time cesareans done for failure to progress and breech presentation. The NIH Task Force especially urged that both these latter reasons for cesarean be examined more closely.

Women want change. CPM has a large and vocal constituency with 40 chapters and more forming every day. Unfortunately, based on the more than 200 letters a week that we receive, 98% of which are from cesarean parents, the climate is hostile for women who seek to avoid a medically unnecessary cesarean. This must change quickly or, as Mr. Raines aptly noted, physicians may soon be sued just as often for performing a cesarean section as for not performing one, adding another chapter to the malpractice saga.

Changes in physicians' practice must happen now to lower our skyrocketing cesarean rate. If the current problem persists, the safer and less expensive alternative procedures will often not be taught to new doctors. As doctors react by practicing defensive medicine, patients lose confidence in the medical profession, to the detriment of both physicians and the public. We believe this problem can be solved. I urge you to act while there is time.

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